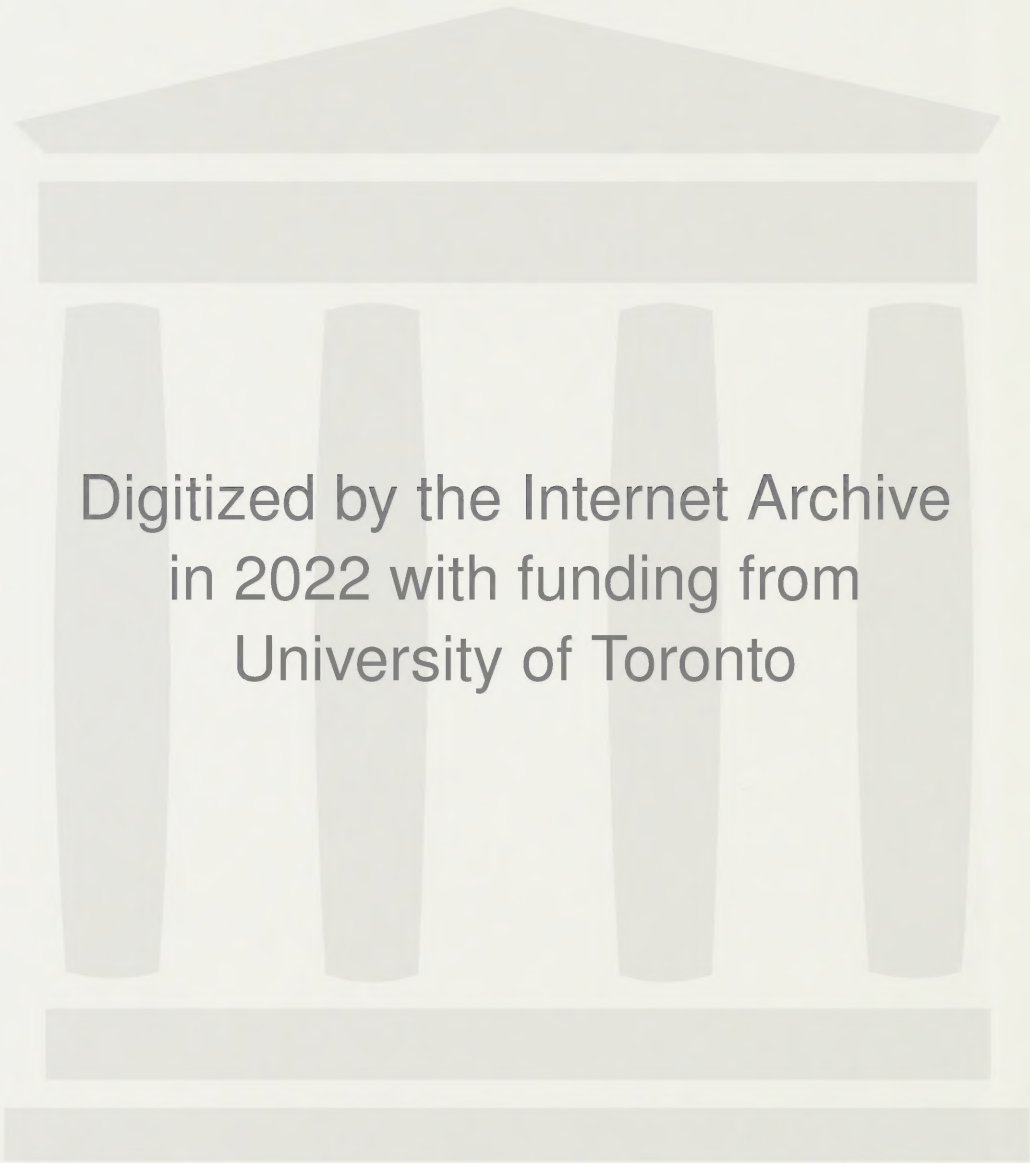

SP-37

ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40e législature

Official Report of Debates (Hansard)

Monday 3 March 2014

Journal des débats (Hansard)

Lundi 3 mars 2014

Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur l'intégration du système de santé local

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

Président : Ernie Hardeman
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Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

Monday 3 March 2014

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Lundi 3 mars 2014

The committee met at 1401 in committee room 1.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): I call the meeting of the social policy committee to order. This is the meeting to continue the review of the Local Health System Integration Act, and the regulations made under it, as provided for in section 39 of the act. I notice that not all members of our committee are here yet, but I'm sure that as soon as they hear us starting this meeting, they will be rushing down to be here. We'll leave it at that.

CENTRAL LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our first presenter is the Central Local Health Integration Network: Kim Baker, chief executive officer. Thank you very much for taking the time to come in and talk to us this afternoon. You will have 15 minutes in which to make your presentation. You can use any or all of that for your presentation. If there's any time left at the end of the meeting, we'll have some questions and comments from our committee. With that, the next 15 minutes are yours.

Ms. Kim Baker: Thank you very much, Mr. Chair. To the committee members, I'm very appreciative of the opportunity to come and speak with you here today. My name is Kim Baker. I'm the CEO of the Central Local Health Integration Network. Prior to coming to the LHINs, I provided critical care to patients as a respiratory therapist. I led the planning and design portfolio for what was at the time the largest health care redevelopment in Canada at the University Health Network. I've also led a national portfolio for community and home care.

In the next 15 minutes, I'll provide you with four examples to illustrate how system performance can be improved, how engagement shapes new models of care for young adults and seniors, how local successes to improve care transitions can be spread across the province and how change is good for patients. I'll also leave you with some suggestions for consideration with respect to strengthening LHSIA.

As proud as I am about what we have accomplished, I know that we have not done it alone. We do it together with our health service providers and other stakeholders. It's collaboration amongst people that will always be key to change in health care. With that, I am going to focus on how people figure prominently in all that we do. We have an office of about 30 people, a nine-member board and a 1.8-million population in our LHIN. That makes us the largest of the LHINs in terms of population. The providers in our LHIN are funded through 112 service accountability agreements. We have six public hospitals, two private hospitals, one community care access centre, over 50 community agencies, over 45 long-term-care homes and two community health centres.

In terms of the organizations we fund, let me tell you about our journey to improved performance. When the LHINs began their work, there were tremendous variations to access for surgical and diagnostic services. In Central LHIN, for example, we used to have significant variations in wait times for MRIs. Depending on the hospital, in any one day, you could wait 20 days at one hospital and be told at another hospital that the wait was 233 days. That's a difference of seven months between hospitals for the same test.

In 2010, we introduced the Wait Times Strategic Planning Group, and set our focus on achieving all of our targets at a system level. The group is made up of senior executives from each of our hospitals and the community care access centre, and is tasked with working as a system. They do this by putting all of the available resources on the table and working within the capacity—be it machine or human resources—that they have and looking at the performance capabilities of each of the organizations.

These meetings are an open and transparent process to develop the best plan to meet the needs and our system targets. We shifted the conversation from organizations coming to the table wanting to know how much funding they would receive to how we could find the best—to working within a set of principles that would deliver for the system.

The proof of this is in the numbers. Since 2010, this effective group helped us achieve significant gains in wait times, which led us to achieve all of our targets for fiscal 2012-13. This means that in just a few short years, patients waiting for a diagnostic MRI got it 77 days faster, patients waiting for cardiac bypass procedures received their procedure 18 days quicker, and patients waiting for cataract surgery got better vision 17 days faster.

And in case you're wondering about the variation I opened with that existed between hospitals, that's now measured in days, and it's just under a month.

So all of these improvements are not only good for patients, but we've also been able to create better stabilization for hospital staff and resources. Central LHIN residents benefit from this collaboration every day; that is, collaboration at the system level, our ability to allocate funding between the hospitals to achieve the right impact, and our understanding that diagnostic and surgical interventions are a very important transition point and ought to be more equitably accessible.

I'd like to now share with you a story of how we've created a new model of care to address a gap in service. This story is chosen because it exemplifies how LHINs are uniquely positioned to make changes in the system for people. It exemplifies how people in the community can influence real change in the context of the LHIN model, and it does have some special meaning for me, I suppose, because I'm also the mother of a child.

In 2013, Central LHIN made funding possible for seven young people with complex medical needs to enjoy a new way of life and live in a home setting at the Reena Community Residence in Vaughan. We did this by breaking through silos and bringing together health care, housing, care coordination and support services to respond to a health care service gap recognized in Central LHIN. We worked across multiple ministries, including health and long-term care, children and youth services and community and social services, as well as our care and service providers, to make it happen.

Just before last Christmas, we went to see how this model of care was making a difference in the lives of the young people living there now. We interviewed a couple of the residents and asked one of them, Andrew, why he wanted to live in this setting at Reena. You see, Andrew is non-verbal, and he relies on a communication board and his March of Dimes support worker to respond. So it took a moment, and Andrew replied to our question with, "To have a life." For 34 years, Andrew lived at home with his loving parents. Today, Andrew is experiencing the joy of living independently with his peers for the very first time in his life.

Andrew has a roommate. His name is Gurpal. Gurpal is 23, and he moved to Reena after living in a hospital for 15 years. Let's think about that for a moment. As just an eight-year-old boy, for Gurpal, the hospital became his home. So we asked Gurpal what he likes about Reena, and he just said to us, with a smile, "I love this place so much."

At Central LHIN, we have a motto: "Together, we're better." Never have I seen a better example of this than with this unique care model. Living together, in a congregate setting in the community with 24-hour care, making friends and having access to life's simple pleasures, these young men are most definitely better together.

The story of Gurpal and Andrew is shown on our website. It's in a three-minute video, and it's also there to help people understand what service is available in the community.

What you don't see in the video is the grassroots origin of this model. You don't see the mother of a young adult with complex medical needs who connected with us and passionately brought her challenges and the challenges of her child to our attention. Our research confirmed it: There was a significant care gap for people like her son in our LHIN. We heard her story.

So, for us, community engagement is not just about the formal opportunities for input but also these informal conversations as well. As LHINs, we're actually close enough to the ground to really listen, and people are benefiting from this every day.

A key reason that this gap in service exists across the province, in fact, for people with complex needs is because these adults are a new cohort. The current system is in place for kids; however, the system for those beyond the age of 18 is not adequately in place, and we're doing something about it.

Other LHINs and sectors also see this, and they're starting to benefit from Central LHIN's model. Just last week, in fact, the March of Dimes hosted an engagement forum with the GTA LHINs. At the forum, they showcased the model to help inspire the development of a congregate housing model for medically complex youth across the GTA.

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Similarly, I'd like to also tell you about a journey to improve the transitions of care and what we call being led by what we hear.

For many seniors with medical complexities and chronic diseases, a hospital admission too often results in two things: resolving the medical reason—why they went to hospital—and a life-altering move to long-term care, not back home from where they came. As you can appreciate, this is pretty frightening for many of our seniors. Because seniors have told us they want to stay home, today in Central LHIN, they have more choices because we've created that capacity in the community to keep seniors at home safely.

To make this a reality, we needed to focus on the transition of care from one provider to the other. We needed to develop mechanisms to focus efforts and measure impact and understand the change.

You see, the transitions of care are those spaces or cracks in between, where providers feel their responsibility ends and the next provider's oversight starts. No one organization owns the transition of care, and all health care organizations have not been created to focus on what happens in those spaces. Only the LHIN is focused on what happens across the whole system, between the cracks. These transitions are becoming so much more important to us as people are being discharged from hospital into the community sicker and quicker.

The result of this focus on the transitions of care is in a story that we often use to illustrate the Home First care philosophy. As a senior with Parkinson's disease, James went to hospital for a life-threatening bacterial infection. Before his hospital stay, James lived at home with his wife. During this stay, James became confused, lost

muscle tone and lost energy. Because his wife works all day, the only option, really, looked like long-term care for James.

James went home with the Home First philosophy, and after two weeks of being home, he was able to move around without the use of any assistive devices, was no longer confused, and has a much more appropriate energy level. James still accesses services in the community and adult day programs, but James has now decided that he'd like to stay home and live with his wife.

This is an example of making the health care system more responsive to what people in our communities are telling us, and it's also better for the system. We've done some of the math on our end and, by our estimates, from diverting people into this new community capacity, we have essentially freed up 35,000 hospital and long-term-care days. That's a value of about $18 million in services. These services were then available to accommodate the needs of people with higher needs. That's all in just one year.

I also know as committee members you're probably very aware of the existing challenges with respect to the mental health care system, and it is fragmented. In Central LHIN, we also continue to have gaps in mental health service capacity and access. One initiative for us has made a difference, which we created in 2008 to centralize access to mental health case management and assertive community treatment teams. Because of this program, there is one place to go to apply for services, making it easier for people to connect with the mental health and addictions services they need. In the event a person is put on a wait-list, there is a service stream that stays with that person until they are connected with a service provider.

This successful solution manages the transition of care and has been adopted by three other LHINs: the Mississauga Halton LHIN, Toronto Central LHIN and, up north, the North East LHIN—another example of a good idea that is being spread across the province and is good for patients.

In closing, I have shared with you four examples of what system transformation looks like locally. We are challenging the status quo and are here to make a change. It can be uncomfortable for some at times. We are making important, objective and informed decisions for better patient care and the sustainability of the system. We are listening and breaking through barriers in a way that's unique to LHINs. If not LHINs, who then? We're publicly reporting our decisions and our results. And we are identifying and improving care transitions between providers.

Central LHIN supports efforts to strengthen these mechanisms to enable the province's ability to transform the system through LHSIA. In your work, I encourage the committee to reflect on and consider the value to the system of making the following changes:

—enabling accountability for primary care to the LHINs, which would support achieving greater alignment among key health system providers;

—strengthening accountability for all organizations to the system and population over the needs of individual organizations. This is required to help ensure that changes are, first and foremost, about improved patient care;

—strengthening the requirement for community engagement at the provider level so that system improvements can be informed by what patients value;

—continuing to push so that the system becomes even more transparent to all; and, perhaps most importantly,

—seeking to understand why the transfer and delegation of authority to LHINs is taking so long.

I do need to emphasize that there is so much more to do. We are not there yet. Ontario needs a mechanism like LHINs to be able to respond and make the necessary system changes that we're aware of today and the ones we will find out tomorrow. The LHINs are uniquely positioned to do this work.

At Central LHIN, we like to use the image of a pinwheel to illustrate what we do. We think of our health service providers as the blades of the pinwheel, and the LHIN, powered by engagement, as the wind that propels the system forward, moving in one direction for a common goal. It's not easy to see or recognize the propulsion behind the scene, but we are there, creating a forward motion that would not happen otherwise, and we're gaining momentum. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have a minute and a half. We'll start with the government side.

Ms. Helena Jaczek: Thank you very much. Delighted to see you, as my riding is in the Central LHIN.

In the documents that you have given us, I'm looking at one where you address us, "Dear Distinguished Members of the Standing Committee on Social Policy," and you talk about LHIN boundaries. You mention that "LHIN boundaries are permeable." But you also have a statistic here that "nearly 30% of patients in Central LHIN hospitals live outside our boundaries, and over 30% of residents receive care outside of the LHIN." Is this causing any difficulties for you in doing your planning since so many of your constituent patients are provided with services outside the LHIN and vice versa?

Ms. Kim Baker: No, we don't see that as a problem in terms of our planning. Thank you for the question. We look at not only the demographics of the people who live in our LHIN, but we're also very aware of the trends in the demographics of the people whom our health service providers are serving. So we work together with our health service providers to understand the trends that we need to accommodate for planning. We see the fact that people move in and out of our LHIN for services as just a reflection of choice. Respecting whether they're residents of our LHIN or residents of other LHINs, they can choose which health service provider they would like to access in the health care system.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That does conclude the time. Thank you very much for taking that time.

Ms. Kim Baker: Thank you.

MISSISSAUGA HALTON LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next presenter is the Mississauga Halton Local Health Integration Network: Bill MacLeod and Graham Goebelle, chair and chief executive officer. Thank you very much for taking the time to come in and talk to us this afternoon. We welcome you. As with the previous presenter, you'll have 15 minutes to make your presentation. You can use any or all of that time to make that presentation. If there's any time left over, we'll have questions and comments from the committee. With that, the next 15 minutes are yours, chair.

Mr. Graeme Goebelle: Thank you very much. Mr. Chairman and distinguished members of the Standing Committee on Social Policy, good afternoon, I am the chair of the Mississauga Halton LHIN. My name is Graeme Goebelle, and I'm joined by our CEO, Bill MacLeod.

Let me first say that on behalf of the board and our CEO, we appreciate the invitation and opportunity to address your committee today. It is an honour and an outstanding pleasure to be here with you in an important time in the LHINs' journey—at a moment when there's so much about our health system being fundamentally transformed. I believe that a better health care system is taking shape, and it's with a great sense of accomplishment that I address you today.

To give you a little perspective about what I am sharing with you and hoping to contribute, I want to begin by telling you that I'm a resident of Georgetown, a part of Halton Hills, a small community in our LHIN where I have lived, worked and raised my family for the last 55 years.

Along with establishing my accounting firm in Georgetown, I've been active in my community, volunteering with many organizations and charities. I have served as a cancer society president; YMCA director; president of the chamber of commerce; United Way chairman; as a director on the Sheridan College Board of Governors, Huron University College Alumni Association, and Licence Appeal Tribunal; a board member of Halton Hills Community Energy Corp.; and chairs of Halton Hills Hydro and the small practices committee of the ICAO here in Toronto.

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For over 30 years, I've been involved with the Georgetown and District Memorial Hospital Foundation as board chair, as well as organizing the annual president's cup golf tournament and Christmas balls. Most recently, I was honoured as Georgetown's Citizen of the Year.

I'm sharing this with you not to boast but to let you know I am not unique. Local health integration network board chairs and their members are people just like me. They live in the community they serve, are professional, are experts in their field, and are passionate about their local health care system. They bring a strong range of skills and experiences and spend time consulting the community and learning about current issues in order to provide good governance and good local health care decisions.

We act as champions for a system approach with other local health care governors, listening and facilitating communication and collaboration, and helping them to achieve their governance oversight responsibilities. That's why, to develop a stronger governance culture across our region, our board has established a community governance consultation group chaired by Ron Haines, our vice-chair, who is here with us today, which includes 13 board chairs from our community service providers. I can tell you, that is a lot of expertise.

We provide input based on our views and expertise as local residents, members of the community, users of the health care system and based on what is important to our local community.

Change is not always easy, however. The purpose and value of local decision-making is that it recognizes and enables local health organizations and solutions to come together, tackle the challenges and take opportunities that are unique to our local area, using local resources. We recognize that the major initiatives often cross boundaries and have shown that they can work together on such matters.

We form alliances to find solutions for health care system improvements. Projects such as the community capacity study, a joint study with our neighbour, Central West LHIN—who are also here today—that will determine our future community needs, demonstrates that LHINs can and do work together and pool funding and resources to determine the needed system level of investment.

At the Mississauga Halton LHIN, we continue to foster and drive opportunities for more efficient and high-quality services in ways that are designed to create new capacity and new partnerships in our communities and for the health system as a whole. These opportunities propel us towards the integrated network that is the core of our vision.

This concludes my brief introduction on our strong local knowledge informing strong local decision-making. I want you to know that I'm proud to be the Mississauga Halton chair, and I'm proud to be working with Bill MacLeod, who is my CEO.

Mr. Bill MacLeod: Thank you very much, Graham. Mr. Chair, members of the committee, good afternoon. As indicated, my name is Bill MacLeod, CEO of the Mississauga Halton LHIN. My goal today is to use my brief time to talk to you about innovation and the spread of innovation, and then the LHIN role in this process.

Innovation is a key process in any system transformation, otherwise known as progress throughout our society and our culture, the essence of which is to find ways of achieving the same or better result with less expenditure of resource. It is sometimes linked to and closely associated with the concept of increasing value for money.

The way the LHINs were created, with local governance and local executive leadership, freed them from the

constraints imposed by a centralized administration and management. This did not guarantee local innovation, but it certainly led to a condition that favoured innovation. Early executive leadership from the ministry at the minister and deputy minister levels also encouraged this approach to local innovation, so much so that someone once quipped, "If you want something done 14 different ways, ask the LHINs to do it," which is exactly the point.

Sometimes the local conditions are so different across our province that one centrally developed solution will not work for every part of the province. Sometimes we do not know the right solution, so the right answer is to create many tests of change to see what does work and under what circumstances. This is a process that most successful enterprises around the world have used to great advantage. However, it is a process that most central governments consistently struggle with harnessing as well.

The issue for the LHINs is that once we have developed an innovation that shows promise or indeed to show that we have a positive impact, how do we spread that innovation to all areas of the province to enhance the benefit to all?

A case example I would like to highlight is the Mississauga Halton Supports for Daily Living program, which was developed under the Home First philosophy. The need for this innovation came about because the Mississauga Halton LHIN has a very low number of long-term-care beds per population greater than age 75, which is the standard ratio measure. This limited access to long-term care caused an increased number of alternate-level-of-care—ALC—patients in our local hospitals. This, in turn, led to limited access to emergency patients who were admitted to hospital and needed a bed but had waited in the emergency department for that bed. Too many patients waited in ER for too long. It was a serious quality-of-care issue.

The Mississauga Halton LHIN saw that it would be possible to develop a comprehensive service, which we called Supports for Daily Living, which could be available for patients who would normally be eligible for long-term care, but it could be delivered economically in the person's own home.

We set about bringing all of the various stakeholders together to develop, refine, implement and monitor this innovation and to address this important need. In short, it has been a great success for the many seniors, clients and families who have been touched by this program and for local health care decision-making in Ontario. ALC rates are down; ER admit waits are down, all at a saving that amounts to millions of dollars over the alternative of building more long-term-care-home beds.

It is such a successful innovation that it has won a national award, the 3M national quality award, and it was this year's recipient of the inaugural minister's quality medal in Ontario.

But this is just one of numerous innovations that LHINs around the province have developed to address important health system issues, always with an interest to increase the value for money offered by the local health care system.

I know we like to talk about our successes, but it's also important, if you really believe in innovation, to talk about our failures and what you've learned from them. In our LHIN, we recognize that one of the risks of shifting care to the community is the increased burden this places on informal caregivers, usually family and friends. This creates something referred to as caregiver burnout. This led us to invest in and create a program called Caregiver ReCharge. It just made sense. Essentially, it was a week of respite care so caregivers could get away to recharge.

What we found, however, was that this was not working as we had expected. It was too restrictive, too structured, and caregivers did not find in it the flexibility to address their full needs. It wasn't being used, and caregivers were not taking advantage of the resources that they needed to give them the necessary respite.

Through a major caregiver consultation program, we were able to redesign and re-launch the program as a more flexible, complete set of resources that we expect will be more suited to caregivers' needs. We have learned from that failure and hope our revised program will successfully address the needs where we see them where the previous one did not.

But then what of the next stage, the spread of successful innovations or sharing the learnings from failures? Using my same example, the Mississauga Halton LHIN was asked by the 14 LHINs collectively to contribute to a document that together highlighted all of the various innovations and successes under the Home First philosophy. Once created, this document was used extensively around the province by all of the LHINs to look for local opportunities to implement the good ideas identified through proven success in other LHINs.

We've also seen the spread of SDL, Supports for Daily Living, to numerous other parts of the province, and this work continues.

The ministry role, in assisting with this spread, was to ensure that a proper policy framework was developed to ensure consistent high quality as the program spread throughout the province. Again, the experience of the Mississauga Halton LHIN was drawn upon to contribute to the policy development work, which ultimately became known as the assisted living policy. In this manner, innovation and spread and consistent implementation are handled appropriately and responsibly across the 14 LHINs.

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Similar approaches to innovation and spread are happening in a long list of important care processes, including palliative care, rehabilitative services, wound care, emergency services, primary care, co-ordinated care for complex patients, and critical care for life-or-limb services—and that list goes on. Each of the 14 LHINs has taken a lead role in innovating and developing and then spreading valuable change processes across the province.

In closing, I want to thank the committee for dedicating their time to reviewing our health care system. I

know that this started as a review of the LHSIA legislation, but it really is a much broader task, I see. Having made health care the focus of my whole career, I think that only good can come from openly assessing what works, what doesn't work and how we can contribute to moving the system to be a better one. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about two and a half minutes. This goes to the official opposition: Ms. Elliott.

Mrs. Christine Elliott: Great. Thank you, Chair. Thank you very much, Mr. MacLeod and Mr. Goebelle, for presenting today.

I'm really interested in the Supports for Daily Living and how you were able to make it so successful, because we know that the transitions often from hospital back into the community are the most troublesome. Can you tell us a little bit about what resources you had to switch around in order to make this program as successful as it was?

Mr. Bill MacLeod: We were fortunate in that, when I first arrived at the LHIN about six years ago, there was an aging-at-home investment developed. It was about $300 million invested in community care to look at aging at home. When we looked at this, clearly the need was in this area of early entry into long-term care. There was a lot of assessment being done, and, because it was the only option, these people were going into long-term care too early.

There were existing pockets of this service, but it was confined to rent-geared-to-income housing, not other areas where seniors lived in congregate settings: apartment buildings and condominium buildings. I myself live in a condominium building. Sometimes people say, "Isn't that a seniors' building?" Based on the average age, it probably is, but it is a place where seniors have said, "You know what? This is the lifestyle I want to live in."

What we found was that the CCAC could deliver services on a per-use basis but not in a way that covered it for 24 hours. The person had a number they could call if they got into any difficulty. There were services delivered throughout the day—not for a full hour, necessarily, but often for 15 minutes at a time, and that was just what the senior needed.

We took that and extended it to wherever we could find seniors in a congregate setting. That, I think, has worked well for us. We're now trying and innovating with a mobile SDL model to see if that will work, because that will spread to, then, other areas of the province.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That concludes the time, and we thank you very much for taking it to be here with us.

CENTRAL EAST LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next delegation is the Central East Local Health Integration Network: Deborah Hammons, chief executive officer. As with the previous delegations, you'll have 15 minutes in which to make your presentation. You can use all or any of that time as you see fit. If there's any time left over, we'll have questions and comments from the committee. With that, your 15 minutes starts now.

Ms. Deborah Hammons: Thank you, Mr. Chair and members of the committee. My name is Deborah Hammons, and I am the chief executive officer of the Central East LHIN.

You may recall that I appeared before the committee back in May 2013 as you conducted a study relating to the oversight, monitoring and regulation of non-accredited pharmaceutical companies. I'm pleased to be back today to share some information regarding the Central East LHIN that I hope will assist you in your task of reviewing the Local Health System Integration Act.

Today, I would like to focus on an aspect of the LHINs' mandate that the team at the Central East LHIN feel is one of our core functions, one that has shaped the look and feel of our organization and other LHINs and the culture since the beginning, and that is community engagement. It is by striving to meet this key objective set out in the LHIN legislation that LHINs are able to create a health care system that is better integrated, sustainable and one that is ensuring better health, better care and better value for money.

The Central East LHIN is home to approximately 1.6 million people and covers a large geography, stretching from the culturally diverse and densely populated Scarborough area up to the rural and less populated areas of north Kawartha, Peterborough county and the Haliburton Highlands, and across to Durham region and Northumberland county.

In the Central East LHIN and, indeed, all 14 LHINs, we recognize that we need to effectively engage with our diverse communities if we are going to continue to make improvements in the health care system.

In June 2006, as we got under way, the Central East LHIN published A Framework for Community Engagement and Local Health Planning. At the time, we said that the framework was our commitment to place collaborative engagement at the centre of our activities. The diversity and complexity of our province demands this type of local focus and local engagement.

In 2006, in order to better address this diversity in our communities, we invited health care providers and community residents to help us. We asked them to join three health networks—seamless care for seniors; mental health and addictions; and chronic disease prevention and management; we asked them to join nine geographically based collaboratives; and we asked them to join five task groups, such as primary care, ALC, rehab, and geriatric emergency management.

Supported by the LHIN organization, this community engagement activity saw hospitals sitting down with community agencies, physicians sitting down with patients, and front-line staff sitting down with administrative leadership. Together, these groups developed and

implemented a number of LHIN-funded initiatives that are still in place and making a difference today.

Now, because of their engagement and collaboration:

Geriatric emergency management nurses are continuing to provide care in the emergency departments of all of our acute care hospitals. The seamless care for seniors network project was the starting point for an improved system of geriatric care within the LHINs and across the LHINs.

The chronic disease prevention and management network led the introduction of a consistent chronic disease self-management model for the Central East LHIN. Eight years later, hundreds of local residents have participated in a free, six-week self-management workshop that empowers them to better manage their chronic conditions. Translated into French, Mandarin and Tamil, this program is considered a best practice in chronic disease self-management and is being used across the province and Canada and around the world.

The mental health and addiction network conducted a number of population health studies that led to new programs for disordered eating, early intervention for youth, and a system approach to providing addictions services.

Community engagement is the foundation of all activity at the Central East LHIN.

We know that being more responsive to local needs and opportunities requires ongoing dialogue and planning with those who use and deliver health services. For the team at the Central East LHIN, this means continuing to talk with and listen to all 13 of our MPPs; all 28 of our municipalities, mayors and local councils; physicians and other front-line health care providers, including family physicians and nurse practitioners; the administrative, governance and managerial leaders of all 138 of our health service providers, many of whom are involved in our planning partner teams; union representatives; patients, consumers, clients and their families; the medical officers of health from our four local public health units; police and emergency management services; the clinicians who sit on our Health Professionals Advisory Committee; chiefs of staff and medical advisory councils from each of our hospitals; other health and social service providers; and local media and the general public. In addition, we hold open board meetings, which the public is invited to attend.

Our website holds all of our public communications, including board reports, publications, technical documents, information on funding, performance dashboards, news releases, feedback surveys, calls for proposals, event calendars, and it even has an area for career opportunities. It also has links to all of our local health service providers, so that people can learn about the services available to them in each of the local communities.

We pay particular attention to key population groups in the Central East LHIN, including our aboriginal communities and our francophone residents. Together with five of our First Nations, we established a First Nations Health Advisory Circle and the Métis, Inuit, Non-Status People's Advisory Committee.

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By working with the advisory circle and advisory committee, we have created opportunities for our aboriginal communities to meet with the community care access centre, the local hospitals and community-based agencies so that information can be shared on the unique needs of their elders and other members of the family, especially for mental health and addictions issues.

We also now have an aboriginal cancer care navigator in our LHIN, and this will be spread across the province.

The First Nations now have access to video-enabled telemedicine units, and a new adult day care program, delivered by the Victorian Order of Nurses, will soon open at the Curve Lake First Nation.

Our relationship with our francophone stakeholders is just as strong because of the partnership we have with the French-language health services planning entity number 4, a partnership that was recently noted by Ontario's French Language Services Commissioner.

Now, because of the partnership, francophone residents have access to the French version of the self-management program, designated long-term-care beds for francophone seniors are available in Scarborough and a new adult program for francophones is soon to be open in Oshawa.

There are other examples where listening to and working with our health care stakeholders and, through them, their patients and local residents, has allowed us to make improvements in the delivery of local health care services:

Cardiac rehabilitation services are now better organized in our LHIN.

New stroke services have been made available closer to home.

Patients who are suffering heart attacks or blockages in their arteries now have faster access to life-saving stenting procedures.

There are more resources in the community for people dealing with mental health illnesses.

Specialized geriatric clinics that provide access to care for seniors in four of our biggest hospitals are now going to be partnered with six new community-based teams so that family physicians are better supported in getting specialized care for their oldest and most complex patients, including how to support patients with challenging behaviour.

Highly specialized thoracic surgery is delivered in the most appropriate setting by experienced doctors and nurses who have the newest equipment.

Vascular surgical services and other clinical services have been sited in the right locations in our LHIN based on what our physicians told us was best practice.

Hundreds of seniors—about 2,200—are now accessing assisted living services so that they can age in place, and a number of integrations supported by strong community engagement have resulted in savings that have been reinvested back into front-line services.

These new and enhanced services are the result of system planning, funding, allocation, accountability

agreements and performance monitoring that all began with community engagement, initiated and supported by the LHINs.

In addition, services that were in danger of closing—such as supportive housing services in Apsley, or the local hospice services in Northumberland county, or the Consumer Survivor Initiative for mental health survivors in east Durham—are now sustainable and continuing to be available because the Central East LHIN brought the stakeholders together, engaged them to identify an integrated solution and ensured that the services were safely transitioned to new providers.

Since February 2012, we have been working with community health service organizations from across the LHIN on a community health services integration strategy to improve client access to high-quality services, create readiness for future health system transformation and make the best use of the public's investment by identifying integration opportunities.

This is an open and transparent process where the LHIN supports the respective agencies in a facilitated integration that sees the agencies engage with their communities to get their input on integration opportunities before any final decisions are made.

The Central East LHIN has supported the Scarborough Hospital and Rouge Valley Health System in a facilitated integration planning process that has seen the hospital engage with thousands of local residents, front-line staff, unions, physicians and other health care providers on a proposed merger between the two organizations.

At the Central East LHIN, we've been listening and talking to people since the beginning. We've invested in the processes, the staff, Web-enabled technology and the time it takes to build relationships, to get to know people.

Some may say that we haven't moved fast enough, that more should have been done over the past eight years. There is always room for improvement. But I would encourage you to consider that, because of LHINs, we are enabling local solutions that are making a difference in our communities through effective community engagement. In the Central East LHIN, we have seen how engaging the community, meeting with local people and working with the local health service providers always leads to better planning, better performance, better outcomes and better value.

I'm very proud of what we have accomplished and look forward to working with our communities and our stakeholders, making even more improvements.

Thank you for the opportunity to speak to you today. I hope I provided you with some valuable input to support the work that you're doing.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. There are just two and a half minutes left. The third party: Ms. Gelinas.

M^me^ France Gélinas: Just a quick question. I appreciate the example you have given us about community engagement. Would you have any recommendations for us moving forward? Are there things that would make your job easier or should be changed, improved or deleted?

Ms. Deborah Hammons: That's a very broad question. If it's related to community engagement, I think that—

M^me^ France Gélinas: No, not community engagement; about the work of the LHINs. We're here to review the LHINs. In the legislation, are there changes that you would like to see in the future?

Ms. Deborah Hammons: Yes. We would like to see the inclusion of primary care, broader than the community health centres that we currently have under our jurisdiction. We are also recommending that independent health facilities, as well, be part of the LHINs. We feel that that's important because, without them, the primary care work that we need to do is more difficult. We'd also like to see the legislation that was enacted be completely enacted, and the regulations as well.

M^me^ France Gélinas: What part hasn't?

Ms. Deborah Hammons: The regulations that are related to our role as it relates to funding; some of the primary care issues that I've just mentioned. We have a briefing that will be coming to the committee that will outline exactly what changes we're proposing in the legislation.

M^me^ France Gélinas: The independent health facilities that you would like coming under the LHINS—all of them?

Ms. Deborah Hammons: Yes.

M^me^ France Gélinas: Do you figure that the people involved are ready for this and that there is a desire, or is this something—

Ms. Deborah Hammons: No. We've actually had some discussions with the independent health facilities. I and one of the other LHIN CEOs gave a presentation in their most recent annual meeting. They welcome working with the LHINs in the future. We're starting to do that work in a very preliminary way, but we don't have the authority, at this point, to take over the accountabilities that we would need to do in managing those organizations.

The Chair (Mr. Ernie Hardeman): Thank you. Thank you very much for your presentation this afternoon. That does conclude the time.

CENTRAL WEST LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next presentation is the Central West Local Health Integration Network: Scott McLeod, chief executive officer, and Maria Britto, chair. Welcome, and thank you very much for being here this afternoon. I just introduced two, and we have three—oh, maybe just getting up to make sure everybody had sufficient water. With that, as with the previous delegations, you will have 15 minutes to make your presentation. You can use any or all of that time to make that presentation. If you have any time left over, we

will have questions and comments from the committee. With that, your 15 minutes starts now.

Ms. Maria Britto: Thank you very much. Good afternoon, everyone. My name is Maria Britto. I am the board chair of Central West Local Health Integration Network.

Reviews of legislation are an important part of our accountability. These discussions allows us to reflect on whether or not things are working as the legislation intended, and they provide us with an opportunity to explore ways of improvement. That's why I'm extremely pleased to be before you here today.

The act is based on a belief that the health needs of local communities are best understood by those who live in them. Because communities are as diverse as their populations, each LHIN faces unique factors that impact the ability to achieve its mandate. For example, the Central West LHIN is very much a mosaic of geographic and cultural diversity. By area, we are the third-smallest LHIN in the province, yet our landscape presents as three distinct areas: urban to the south, a combination of urban and rural in the middle, and rural to the north. By contrast, we have a large, growing and diverse population. Over half of our residents are made up of visible ethnic minorities, immigrants and those who are new to Canada within the last five years. As a realtor myself, a business leader and board chair of this LHIN, I frequently travel across all areas of our LHIN. Through my own experiences, and those told to me by the people I meet every day, I'm intimately familiar with the unique challenges that exist because of our population growth and geographic and cultural diversity. Perhaps this goes without saying, but I may know a thing or two about the challenges our local residents face when it comes to ethno-cultural diversity.

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LHINs are doing the job nobody else can do, because they have the best and only real view on the ground. As a result, they work to meet the ever-changing specific needs of each geographic area. I came to the central LHIN knowing some, but not a lot, about the LHINs. But I came knowing the value of relationship building, community engagement, knowledge exchange and collaboration. Since joining Central West, I've come to fully understand and appreciate the value that the LHINs offer to our health care system.

At the Central West LHIN, we've always worked to ensure health services are working together, more collectively and collaboratively. Because our board members reside locally, within the LHIN, we are better able to understand the needs of our communities, and we also have a professional and personal investment when it comes to ensuring its operational effectiveness.

Most importantly, however, the ability to effectively understand the needs of our local communities rests with meaningful community engagement and relationship building, both of which are at the heart of how we work at Central West. I am particularly proud of the relationships we've been able to cultivate in our area with our residents, our health service providers, and those organizations that are not funded by the LHIN, but play an important role in the design and integration of their local health care system.

We have the fewest number of health care service providers in the LHIN, a unique factor that enables us to build very strong and meaningful relationships with all of our health service providers, at a governance level and beyond. It allows us the opportunity to regularly bring them together for educational purposes, as well as to provide input into planning and funding priorities, all with a focus on improving access to high-quality, person-centred care for our local residents. I know for a fact that, as a result of these efforts, governance in the Central West LHIN is right on track.

Since the LHINs were introduced, an increasing number of local residents feel their health care has changed for the better. With system building there will always be room for improvement. We are further ahead today than when the local health integration networks were first established, a point that cannot be lost on this committee, and one for which I am extremely proud.

I would now like to invite Scott McLeod, my CEO with Central West LHIN, to take you through some aspects that we feel are important from the perspective of how the Central West LHIN operates within the LHSIA framework. I'll also remind you that I've been told by the communications people to nudge him a bit to make him smile more.

Mr. Scott McLeod: There you go. I'm smiling.

Thank you, Maria, and good afternoon. My name is Scott McLeod, and I am the CEO of the Central West LHIN, a role that I've had for the past 17 months. I've been in health care all of my career, and bring a diverse experience—from three different provinces and a number of health authority provider and planning organizations—to the work that we're doing in Central West, and collectively across all LHINs. Having followed with interest the discussion of the committee these past months, I want to take some time to address some key areas we feel warrant perhaps further discussion and further understanding.

An area of interest that has emerged from these discussions seems to be around performance measurement. How do the LHINs measure their success, and by extension, have they been able to improve the health care system? During your meetings, you've heard many stories of front-line impact, the difference that LHINs have been able to make towards attainment of better, high-quality, person-centred care. They are strong, moving, and important testaments of how residents are experiencing their local health care systems.

You have also heard a lot about our accountability agreements and system indicators that are used to measure performance on a more quantitative basis. I do believe we have meaningful system indicators that demonstrate how improvements have been made and are continuing to be made.

In addition to the ministry-LHIN system performance indicators, Central West also reached out, through public polling, to local residents of the LHIN to understand if

we are making a difference. Over the past eight years, we have been able to assess our local residents' overall satisfaction on a number of important areas, including access, quality, sustainability and equity. Our latest poll, conducted in September of last year, involved a random sample of 600 residents from across the LHIN. The results reveal 88% of the residents indicated they are satisfied or very satisfied with the quality of the health care services, and that's an increase of 11% since 2009. Results also show improvements in satisfaction with accessibility to local health care services, including doctors and specialists. Some 82% of local residents are satisfied with the system's capacity to accommodate diversity, and 78% with the system's ability to provide fair and equitable services for all.

With respect to performance, our residents have let us know that, in collaboration with our health service providers, we're on the right track, that our planning and investments are making a difference. While these are positive results, it also demonstrates that there are real opportunities to continuously improve.

Our communities in Central West have seen significant population growth over the last 15 years: 27% growth since 2001. Today, there are about 840,000 people living in Central West, and the population is projected to continue to grow at one of the fastest rates in the province. By 2021, the population is projected to grow by 23%.

In contrast to the growth we have seen, Central West has the fewest number of health service providers of any LHIN in the province. Our providers have struggled to keep pace with growing demands for health care across all sectors. This poses a challenge for decisions related to resource allocation, but it also has resulted in great innovation within and among our health service providers, who continually look for ways to become more efficient while driving quality improvements. However, we are especially pleased that new approaches to funding based on population and quality will, over time, enable continued local investment to better match the demand for health services. Continued investment in Central West is essential.

Residents often leave Central West to access mostly speciality services in neighbouring LHINs. From a patient/resident perspective, LHIN boundaries are permeable. This means that we must, and do, work closely with other GTA LHINs to ensure access, flow and as much consistency as possible.

To support our collective work, we have established purposeful structures where we table issues, consider solutions, advance consistency, and look for opportunities for spread. Two examples include the GTA CEO meetings, and the central Ontario eHealth steering committee, both of which meet monthly. We also work together on joint planning initiatives such as the community capacity study referenced by Bill MacLeod. In fact, you will see considerable cross-LHIN planning on many, many fronts. And there is always room for improvement.

As you may know, MPP Cansfield has four LHINs and four CCACs that intersect within her constituency. She will tell of the concerns raised about variability in access to CCAC services, depending on where you live. This is an area where, in collaboration with CCACs, we have work to do to ensure greater consistency.

This has sometimes been referred to as a LHIN boundary issue. If I can impress upon the committee one thing, it is that there are no perfect boundaries. Structural change is comparatively easy to make and is where many across the country have gone first when system change has been required. We should learn from the experience of other provinces: Structural changes have not solved the problems, and arguably, they have set the system back because of the disruptions they cause. I believe we'd be much better served by focusing on consistent integration strategies to address issues and challenges across the LHINs with local execution, rather than focusing on boundaries. That is what we focus on across the GTA LHINs and across all LHINs.

In Central West, our size provides us unique nimbleness, an ability to quickly find common ground and sense of common purpose so that we can move quickly to implement new programs, services and initiatives, such as health links and Telehomecare. Telehomecare is a highly successful program that's seeing great results. Central West was one of three pilots to implement this innovative approach beginning in February 2013. The purpose of the pilot is to help residents with chronic conditions, such as congestive heart failure or chronic obstructive pulmonary disease, better manage their conditions more effectively. Patients with these chronic conditions often go to emergency departments or are admitted to acute care. The program leverages technology put into patients' homes to allow them to monitor their conditions more effectively.

To date, close to 650 residents have been enrolled in the program with dramatic results. We have tracked ED and acute care utilization pre- and post-enrollment, and the results demonstrate a remarkable 48% reduction in ED visits and a 76% reduction in admissions to hospital. The results are compelling and other LHINs are now looking to implement this innovation.

Central West, along with our providers, has enthusiastically adopted health links. Again, by being nimble, through the development of strong, productive relationships, we were among the first to have our entire LHIN covered by five health links. As you know, health links are being established to help fundamentally transform our system by focusing first on the highest users, ensuring that care and services are wrapped around individual patient needs.

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One of the things that I believe makes health links so potentially game-changing is that many of the solutions to improve the health of the patient come from outside the health care sector, and that's certainly been our experience in Central West. Health links enable us to bring a broad mix of social and health service providers to the table to help find better solutions for individuals.

We are still in the early days of health links, and there will be bumps in the road, but, together with our local steering committee, we identify and problem-solve to ensure the five health links learn from each other and are implemented consistently across Central West.

We have much to be proud of, and we work collaboratively with our stakeholders and health service providers. But I don't want to leave you with the impression that everything's perfect. We don't always agree and there's lots of healthy debate. However, with strong relationships in place, difficult conversations can be held with the best interests of local residents top of mind.

When we speak of change, it's important to remember that while our Canadian health care system—a system that the majority of Canadians have come to embrace as a part of their identity—formally emerged in the 1960s, it has been around for over 100 years. I have never heard anyone say that if we were designing the system today, it would look the way it does today. When we talk about transformation, we talk about changing how things are done, and change, as we know, is difficult. My point here is that, with all the positives and ongoing opportunities, it is a system that has taken a century to create and will take more than eight years to fundamentally transform and integrate.

The act is incredibly powerful legislation. Incorporating the changes you've heard about and the recommendations put forward from the LHINs will enable us to further advance change and transformation.

So, in closing, have we made collective improvements to the system? Absolutely. Are LHINs committed to the fundamental transformation required? Absolutely. Do we need to challenge the status quo and resistance to change? Absolutely. Do we still have a lot to accomplish? Unquestionably. Are we up to the challenge? Let there be no doubt, the answer is a resounding yes.

Members of the committee, once again, my thanks.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have just over a minute. Ms. Jaczek.

Ms. Helena Jaczek: Thank you very much. Ms. Cansfield is not able to be here today. She's on another committee. So thank you for addressing her issue. She's been talking about it for many years.

What are the barriers to you achieving that consistency between CCAC services, between the four of you that service her community?

Mr. Scott McLeod: There are probably a couple. There are different allocations of resources, basically. I think part of it comes down to a funding issue, but the other part is a practice issue, and agreeing on what the upfront priorities need to be across the four, particularly where they intersect. While it may apply to the GTA in particular, I think it applies to all CCACs, not just the four within MPP Cansfield's riding.

Ms. Helena Jaczek: Thank you. Go ahead.

Mr. Vic Dhillon: Thank you very much for—

The Chair (Mr. Ernie Hardeman): Thank you very much for your time. That does conclude the time. Thank you very much for your presentation.

Ms. Maria Britto: Thank you.

Mr. Scott McLeod: Thank you.

CANADIAN MENTAL HEALTH ASSOCIATION

The Chair (Mr. Ernie Hardeman): Our next presentation is from the Canadian Mental Health Association: Camille Quenneville; Marion Quigley, chief executive officer of the Canadian Mental Health Association, Sudbury/Manitoulin; Steve Lurie, executive director, Canadian Mental Health Association of Toronto; and Tim Simboli, executive director, Canadian Mental Health Association of Ottawa.

The committee will be aware that this presentation is one that fits with the first opening days of our committee hearings, which will be a two-hour presentation in its entirety, and which will consist of half an hour allotted for the presentation and half an hour for each caucus to ask questions. We'll allow everyone time to get settled in.

Thank you all very much for coming in and taking the time to be with us this afternoon. We will have a two-hour time slot allotted for the presentation. We'll hopefully have about a half an hour for your presentation, and then we'll have a half an hour for each caucus to have questions or comments about the presentation. For those in the audience who are present, the difference between the presentations is that we had a number of these from different organizations—general, province-wide organizations—when we started the hearings to, shall we say, enlighten the committee about the scope of our review. At that time, we set up the two hours for each one of those organizations. This is one of those as opposed to, we then went about getting everybody a 15-minute presentation and hearing from as many of the LHINs and other organizations that we possibly could.

With that, welcome. Your time starts right now.

Ms. Camille Quenneville: Thank you, Mr. Chair and members of the committee. We're very pleased to be here today to share our views on the Local Health System Integration Act with you. I'm so pleased to introduce my colleagues, leaders in three of our branches: Marion Quigley from our Sudbury-Manitoulin branch; to my far left is Tim Simboli from our Ottawa branch; and of course Steve Lurie from our Toronto branch. Marion, Tim and Steve all agreed to participate with me today to offer up a regional perspective when we are answering your questions.

I know that a few of the MPPs around the table today also served on the Select Committee on Mental Health and Addictions. Before the select committee began its deliberations, a number of you publicly expressed your interest in improving the mental health and addictions sector in our province. I know from experience that the MPPs who served on the select committee, amongst others, continue to have a keen interest in shining a spotlight on the tremendous need that exists in the mental health and addictions sector. While our task today is to

discuss the Local Health System Integration Act, I think it's important to point out that the MPPs here possess a better-than-average understanding of the mental health and addictions sector, and for that, we feel very fortunate.

About CMHA, Ontario: Let me tell you a little bit about who we are. Before we get into the details of the act, I'd like to share some background on our organization.

The Canadian Mental Health Association was founded in 1918 and is amongst the oldest voluntary organizations in Canada. Across the country there are 120 branches, and here in Ontario there are 31. We serve approximately 50,000 Ontarians each year through a myriad of programs that include housing supports; public education programs; counselling; court supports and justice-related services; seniors programs; family programs; wellness; workplace mental health etc. I could go on. Our mission is to make mental health possible for all.

I'd like to offer a personal observation about our work for a moment. The success of CMHA is directly related to our branches offering programs that respect their local population and reflect the community they serve. As a relative newcomer to this organization, it has been my observation, as I've travelled across Ontario, that our branches have responded to the changing needs of their communities. In some cases, for example, this means offering programs to support seniors suffering from isolation and depression in communities where the population is aging.

Fort Frances is a good example. As the paper mills closed and industry moved out, so too did the next generation—not surprisingly. The CMHA branch has a clubhouse model which seniors can access daily, providing them with a social network and additional supports for living independently, which helps them remain in their home and out of more expensive mental health or long-term-care programs and facilities. This is "community-based" at its best, in my view.

This is one example of many across the province which serves to reinforce the value of community-based services. The Drummond report references the value of the community-based system and the importance of ensuring that any changes to the system put the client at the centre, and that has always been our belief. I'm proud to tell you that our work puts the client at the centre.

I would like to share two brief stories to give you a further sense of our work across the province.

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A gentleman who we will call "James," which is not his real name, was referred to the Mental Health Court diversion program of our Leeds-Grenville branch, in Brockville, following a charge of causing a disturbance. James was 48 at the time, of aboriginal origin, suffering from bipolar disorder and, when he was unwell, presented very loudly and with rapidity of thought and expression. He came across as agitated, belligerent, argumentative and verbally combative. At six feet tall, he may be perceived as threatening, but he was not acting out. At the time of his referral, it was learned that James was a survivor of childhood sexual abuse and a chronic user of cannabis, and was not taking his medication. He had also not seen his physician for a significant period of time and was estranged from his case manager.

Through the Mental Health Court diversion plan, James agreed to reconnect with his physician and participate in the psychiatric outpatient referral, be amenable to treatment recommendations, have regular contact with a case manager and check in regularly with the CMHA court diversion worker while maintaining the peace. James successfully completed the plan in May 2013, and his charge was stayed. Throughout the diversion process, James attended appointments and maintained contact with his case management team. He has subsequently ceased use of cannabis, re-engaged with his psychiatrist and is medication compliant. At his request, he maintains contact with the court diversion worker and now drops in to say hello. There has been no known additional police involvement at this time.

One last brief story: Larry Woodhouse, a gentleman I spoke to again this morning—which, I should tell you, is his real name; he insisted, in fact, that I use it. He has been accessing service at CMHA Oxford County. Larry came to learn about CMHA when his supervisor noticed that he was not coping well in the workplace and invited staff from CMHA in to speak with him. Larry said that at the first meeting with these staff, he learned coping skills and was given the number to the CMHA crisis line in the form of a fridge magnet. He used the number frequently and subsequently received case management services with our branch. Larry had a history of mental illness and suicidal ideation, and he has indicated that in no uncertain terms, he is alive today because of CMHA. He has been asked to speak publicly about his experience by Mike McMahon, the executive director of the Oxford county branch, which he has done, raising money for the local United Way, which also funds the branch. Larry described his numerous speaking engagements as "kinda cool" and a highlight of his life.

The Local Health System Integration Act: One of the advantages of not being amongst the first to present to the committee is that you have the benefit of hearing and reading what others who have gone before you have said to understand different viewpoints. I read the presentation by Saäd Rafi, the former Deputy Minister of Health and Long-Term Care, with great interest. The matter of how the regionalization or decentralization of health care services came about and the evolution of the LHIN structure is a matter of public record. So too is the purpose of the act, "to provide for an integrated health system to improve the health of Ontarians through better access to high-quality health services, coordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by local health integration networks."

We're not the first province to go down this road and, while we could debate today whether we should have, what we could do or what should exist instead of the LHINs, we would prefer to focus our comments on the

existing structure and offer up some observations to share with you. In part, this is due to the fact that, representing 31 branches across 14 LHINs, it is perhaps not surprising that experiences differ. Overall, we are supportive of the LHIN structure. We would like to highlight what has worked particularly well, and offer up some areas where there is some room for improvement which we hope will assist you in your deliberations.

For the purposes of this presentation, we'll mirror the contents of the Local Health System Integration Act and provide comments on community engagement, funding, accountability and integration. We'll also provide further thoughts on quality improvement and governance, both of which are integral to the system, in our view. We'll also reflect on the recommendations contained in the Drummond report, which we understand have been referenced throughout this review exercise as well.

Community engagement and governance: Some LHINs operate with an openness and transparency to their work. They engage local boards as well as staff of community-based organizations. But this is not always the case. CMHA welcomes interaction at a governance level with LHIN boards. It has been our experience that this has been a fruitful endeavour for both parties and has been mutually beneficial and necessary when large undertakings, such as an amalgamation of organizations, takes place. It is a good example of how working together brings change to community, LHIN and CMHA local branches.

This government has brought forward many initiatives in reforming the health care system. The LHINs are an important example, but so, too, are the more recent service collaboratives and health links. They are all valuable, and there are many examples where they have been very successful. However, community-based organizations, such as our branches, often struggle to keep up. There is a strong desire to be at every table, and indeed there is an expectation that we will be. But the administrative burden is high, and without a clear provincial objective of how all of these initiatives interrelate, it can become unmanageable. We are hoping that, with the pending implementation of years four through 10 of the 10-year strategy, we will have assistance in providing clearer provincial direction.

Provincial governance: We are pleased to be part of the ongoing discussion about years four through 10 of the mental health strategy with the Ministry of Health and Long-Term Care. While the ministry considers its future priorities regarding mental health and addictions, we would simply reflect that dramatically changing the governance structure of mental health and addictions, as stated in the Select Committee on Mental Health and Addictions report, is not a priority for us at this time. The resources necessary to do so would be far better spent providing additional housing and other mental health and addiction related supports. Much can be done within government and the community-based system to better coordinate programs and service delivery, including through the LHIN structure. There are currently far more ministries than there ever have been focused on mental health and addictions, and there are structures and processes within government that could link them together. They need to be utilized. The Canadian Mental Health Association is currently exploring options, along with other community partners, on how best to achieve efficient system-wide planning provincially.

Funding: To begin with, we would like to offer up some data to show both the size and scope of the need for mental health care from a global, national and provincial perspective. Some of this information comes from a document that my colleague Steve Lurie has produced on the current system titled Why Can't Canada Spend More on Mental Health; it's in your package. This will be formally published very shortly, and we have provided copies for your interest. These statistics are really just to demonstrate the scope of mental-health-and-addiction-related issues and why it's necessary to get the funding and delivery system right, first and foremost for the client and their family, for our health care system in communities and for the economy as a whole.

It is worth noting, from a global perspective, that the World Health Organization notes that mental illness accounts for 13% of the world's disease burden. We are falling behind other high-income countries when it comes to spending on mental health, at 7.2 %, compared to most others which spend 10% or more.

In Canada, the following points reflect the impact of the lack of available treatment and supports nationally, the resulting effect on our economy and also how mental health compares to physical health issues. The Mental Health Commission of Canada has indicated that as few as one in three adults and one in four children receive mental health treatment and support when needed. The commission has also noted that the cost of mental-health-related issues is $50 billion per year to our economy. Some 6.7 million Canadians out of a total population of 37 million are living with mental illness, compared to 2.2 million who live with type 2 diabetes. The Mental Health Commission of Canada recommends that at least 9% of health spending should be on mental health, and a further 2% increase in social spending is also needed.

In Ontario, the Drummond report cites that "estimates of the economic costs of mental health and addiction are pegged at $39 billion annually, with productivity losses accounting for 74% of the costs."

According to public accounts, community mental health funding comprises 2.5% to 3% of LHIN funding. As previously mentioned, the mental health commission has stated it should be 9%.

There are 441,027 unique individuals served by all community mental health and addictions programs annually in Ontario, at a cost of $51 for these services compared to $138 for in-patient/physician-based mental health services. As stated, these figures demonstrate the tremendous need and funding shortfall that exists. We use this information in working with the Ministry of Health and Long Term-Care and with the LHINs to reinforce the need to make further strategic investments.

The Drummond report recommended the following: "Support a gradual shift to mechanisms that ensure a continuum of care and care that is community-based. Funding for community-based care may need to grow at a higher rate in the short to medium term in order to build capacity to take pressure off acute care facilities; on the other hand, with a shift away from a hospital focus, hospital budgets could grow less rapidly than the average."

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There is evidence of this over the past few years, and there's no doubt that further investments in housing, peer support, employment, case management, assertive community treatment, early psychosis intervention etc. will further alleviate the higher costs associated with hospital or institutionalized care.

Funding coordination: There are some practical implications to having two funders for some community-based services. Specifically, the funding for supports within housing is the responsibility of the LHINs; the funding for bricks and mortar and rent supplements lies with the Ministry of Health and Long-Term Care. As previously indicated, housing is the highest need across Ontario when it comes to supports for those living with mental illness and addictions. The process for getting approval for new housing with supports, however, is exceptionally difficult to navigate because it requires coordinated funding. In one particular branch example, the Ministry of Health had provided funding for rent subsidies, but this did not correspond with additional staffing dollars from the LHINs, leaving the agency to manage considerably more service with existing staff. That same agency received a sizable investment of additional dollars from the city where they're located for considerably more rent subsidies over a five-year period, but again, the LHIN would not approve additional resources in the form of additional staff to manage increased service delivery. This makes any attempt to sustain a "housing first" approach extremely difficult within communities, despite the fact that considerable literature points to this as a worthy goal.

Funding transparency: While soliciting feedback from our branches for this presentation, it was noted that often funding is not applied equitably or consistently across the system. Perhaps not surprisingly, there is strong competition for dollars and a lack of clear direction on priority items as it relates to funding. Dollars may be provided to new start-up programs, leaving those programs that had proven successful without resources. This points to the need for better coordination more than anything else. Strong partnerships must rely on healthy communications so that all partners feel engaged and included in how decisions are made.

Definitions: There is a further sense of a lack of coordination amongst LHINs around fiscal matters. This is best evidenced by different definitions that are used across LHINs. Some branches are advised that their administrative budgets include rent; others do not. Some suggest that the cap is a certain percentage, and it may be very different in the neighbouring LHIN. This is clearly not deliberate and not intended to handicap any organization; however, simple agreement amongst the LHINs on the terms and their use across the province will help organizations achieve their targets and share best practices more easily with one another.

Accountability: Considerable effort has been made to engage the community-based organizations on the refinement of the M-SAA, or multi-sector accountability agreement. The M-SAA table has met very regularly under the able leadership of Louise Paquette of the North East LHIN. There has been a respectful exchange, and ideas raised by the community sector were listened to and taken into consideration for further decision-making. It has been a good process, and we're pleased that it will continue into the future. This partnership-building is important for all parties. The community-based sector worked hard to do their homework, to offer up important insight, and provide the best possible information and feedback to the larger group, which we hope and believe was beneficial to the LHIN table and will ultimately be seen in a much more workable, agreeable M-SAA template for all parties.

Quality improvement: As you know, The Excellent Care for All Act legislates annual quality improvement plans for every health care organization. The Canadian Mental Health Association in Ontario has embraced this requirement. Before we were mandated to do so by the local health integration networks, we set to work provincially to develop our own template for use in mental health and addictions. Leadership for this exercise began with our executive director network, made up of the CEOs of all 31 branches, who meet regularly throughout the year. Linda Gallacher, CEO of the Durham branch, spearheaded our efforts in this area by engaging a small working group of her colleagues to initiate a plan of action.

It was recognized early on that the templates that were being developed by hospitals had little relevance to the community-based system of mental health and addictions, so we set out to develop our own. Surveys were conducted to see what amount of work had been done on quality improvement within our branches. Armed with that information, a working group of skilled staff in our branches was struck, and they, in turn, developed a draft template. The template was then shared with Addictions and Mental Health Ontario for their input. To their great credit, they were very willing and anxious to work with us to ensure that the template was suitable for their agencies as well, so that ultimately we would have one template for the entire sector.

David Kelly, executive director of Addictions and Mental Health Ontario, and I have worked together to bring this template to provincial officials including Health Quality Ontario and the Health Quality Branch at the Ministry of Health and Long-Term Care. The template has been well received, and we have subsequently been asked to consider what resources might be necessary for its implementation. We have done so and submitted a proposal to the ministry.

I raise this with you to demonstrate our efforts in partnering and ensuring we are meeting and exceeding all requirements of the ministry and our LHIN funders. This partnership is one example of many that happen provincially to ensure the best use of resources across mental health and addictions as well as other broader social service organizations.

It must be said that while a focus on quality is important, for us to achieve success, quality must be objectively measured through standardized methodology using consistent definitions. Having the capacity within organizations is also critical and, at the moment, all of these criteria are missing. We will continue to advocate for these needs.

Integration: Since the advent of the local health integration network, a considerable amount of integration has taken place across the health care sector. Some of it involves bringing programs together and, in some cases, organizations, in an attempt to enhance service delivery. The CMHA has done a great deal of work in integrating primary and mental health care, and we will continue to play a role as a resource to the LHINs for this work.

It has been our experience to date that the most successful integration of community-based organizations has resulted from local decision-making by interested parties. The parties identify where they could collaborate or, in some cases, merge to benefit the consumer, and present the concept to the LHIN. With LHIN support and guidance, these mergers have worked well to the benefit of the most important stakeholders—those accessing the service. It is our view that the decision to integrate services or merge organizations should be taken with only this stakeholder group in mind: the consumer. These decisions should focus on how the consumer can best access the most appropriate service in the right place, at the right time. As the Drummond report recommended, "The system should be centred on the patient, not on the institutions and practitioners in the health care system." We are pleased that many of our branches have expanded as a result of integration with other organizations to provide better access to the most appropriate treatment for our consumers.

We have been concerned in some situations where the focus appears to be integration for the sake of integration, with simply having fewer organizations being the objective. In some cases, the decision to integrate organizations has not followed a constructive process involving stakeholders. We would respectfully recommend that the following steps be considered before formal action is taken to merge organizations:

—focus solely on client service as the primary objective;

—analyze client data from across the catchment area to ensure there is evidence of the need for system change. This can be done by using the Ontario perception of care tool for mental health and addiction services. This will allow for a representative sample of the needs of the community;

—conduct a thorough cost analysis in a transparent fashion. It should include the following measures: a human resources cost impact analysis of merged unionized and non-unionized positions regionally, if applicable, as well as hospital and community-sponsored wage grids; harmonization costs across sectors, as well as pension, benefits, employment contracts and severance costs to be borne by the LHIN; incorporation and dissolution costs attributable to agency mergers to be borne by the LHIN; long-term lease and mortgage commitment transfer costs where applicable to be borne by the LHIN; and legal costs inherent to dissolution and new incorporation to be borne by the LHIN;

—consider that there is comprehensive literature that exists detailing the negative impacts of forced mergers and the benefit of strategic alliances. The alliances can be more successful at less cost; and

—consider all options, including other investments, that may prove more beneficial for local service delivery, such as electronic infrastructure, to assist in the effective utilization of records for all providers.

Most concerning is the myth that integration saves money. Often there are insufficient resources to start, leaving no savings at the end of the process. Instead, CMHA, Ontario recommends that the decision to integrate be made based on what makes the most sense from a client perspective, including how to access the system.

In conclusion, we're pleased to partner with the local health integration networks across the province to provide the very best service to consumers in need of mental health and addiction supports. We believe that only through respectful collaboration can we ensure that the system is operating efficiently and well, and to the benefit of the consumer.

We provided a number of recommendations through this presentation, all of them doable, and we are happy to be engaged with all 14 LHINs across the province in achieving our collective goals.

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Our recommendations include:

—additional emphasis on openness and engagement with the boards and staff of community-based organizations;

—transparency in funding decisions;

—a recognition of the need for further investments in our sector to meet the needs;

—clearer definitions on financial matters;

—agreement on standardized methodology to ensure our quality improvement work is successful and meaningful;

—integration for the sole purpose of improved client service; and

—an open, transparent, engaging process with community partners before proceeding.

Thank you for the opportunity to appear here today. A special thanks to the Clerk of the Committee: Valerie, thank you. We appreciate your efficient response to our request to appear. Along with my colleagues, I am very pleased to answer your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We will have half an hour

for each caucus. It starts with the official opposition. The questions will not necessarily be the full half-hour for each one. We'll make rotations until all three parties have either ended their questions or run out of time.

With that, Ms. Elliott.

Mrs. Christine Elliott: Thank you, Chair. Good afternoon, everyone. Thank you so much for your great presentation.

I had a question regarding the examples you gave us about CMHA, Ontario and the Mental Health Court diversion plan, how you were able to connect with them and get them to work with you, because some of the presenters who have come have talked to us about integrating not just health services but some of the other social agencies that are involved with the police, with the courts. I'm wondering if you could give us any guidance on how you went about that and how we could integrate other groups that have an impact on mental health into—

Ms. Camille Quenneville: That's a great question. Thank you. One of the nice benefits of having the folks here who run these organizations is that they can give you very specific examples. So what I might do is just ask if all three of you could maybe respond briefly to that, and then I'll give you a provincial—

Mr. Steve Lurie: Well, I think that at both the provincial and regional tables we've got the Human Services and Justice Coordinating Committees, and that brings together hospitals, the police, the crown attorneys. That's often where many of the ideas to develop a mental health court or build a diversion program come from.

I think the HSJCCs have been, actually, since 1998—and I've been chairing the Toronto group since that time—a very effective means of joint planning and collaboration across the sectors, but their challenge is the same one that Camille mentioned. The resources aren't on the ground, so you can't develop a diversion program if there isn't money to fund it. If you fund a diversion program and the services that people need to be connected with don't exist in the community, then there are similar problems.

The Making a Difference report which was done around the service systems evaluation initiative launched by this government showed that in fact the court diversion programs are quite successful and they were able to lower the amount of time to get services, but after three years, the range of services that people needed in the community weren't available.

Mrs. Christine Elliott: I see.

Mr. Tim Simboli: I'm with the Ottawa office, so we're in the Champlain LHIN. Two things that I think have worked well for building that kind of integration are, first, we actually have a number of subgroups that work on a local level, mental health community support services, a network of community health and resource centres that operate in Ottawa that have a connection to the mental health services. So there's a number of bodies where front-line middle management and senior management connect together, and I think it's important that each level—we mention governance levels in here, but that there's a connection at each level.

The other thing that I think has been effective for us is, we do a fair amount of outreach services. We have teams that go into the courts, the shelters and the hospitals. That's where they go to find the clients, and, for the most part, agencies that are working with these clients are well advised to be there on the ground and make those kinds of connections. It's a doorway. It's a personal invitation that can be made to people so that they can then connect with our more fulsome services.

Ms. Marion Quigley: I'll just add that in northeastern Ontario, what happens is there are good connections with the human service justice programs where the other programs don't have as close a connection because they don't have the same types of tables. They do have the mental health and addiction table. But some of the community support agencies in the north, we find, don't have the resources to come to all the meetings to make those connections. That's where I see a bit of a lack with the outreach.

Ms. Camille Quenneville: And finally, I think it's worth noting that, as my colleagues have referenced, the justice coordinating committee, which we call HSJCC, the Human Services and Justice Coordinating Committee—that work is done through the Ontario division office. We have a full-time person who works on that.

Mrs. Christine Elliott: Well, I would agree with you just on what I've seen. They seem to be very, very effective in triaging people out of the criminal justice system when they don't need to be there.

Ms. Camille Quenneville: Yes.

Mrs. Christine Elliott: Another question I had was just on the issue of integration. You have expressed some concerns that any integrations done be done for the purpose of improving service for people. Do you get the feeling now that integration is happening more than it should be? Is it being pushed a little bit more than you'd like to see?

Ms. Camille Quenneville: In some cases, yes. I think, in part, there's sometimes a lack of understanding of the partnerships that already exist within our branches and how on the ground there is very good collaboration amongst different community organizations that are working to serve a particular client or group of clients. It's really the broad spectrum, to be quite honest. We've had very successful integrations and a couple of our branches have grown quite dramatically as a result, and they've gone very well in large measure because those decisions were taken locally and there was a real desire to come together and it made sense for the community in terms of how best to serve clients. Others have been entered into without the homework having been done, so they really haven't been quite as smooth.

I don't know if my colleagues want to comment on any of that.

Mr. Steve Lurie: Well, I guess there is a literature on integration. Just to briefly summarize what Camille referred to in the brief, there's lots of evidence, actually, that 80% of mergers in the public and private sectors fail. So if merger is your default, you're likely not to succeed.

Strategic alliances are known, according to the Harvard Business Review, to be an effective way of bringing groups together. For example, I think you could say a human service and justice committee or a mental health and addiction network is a kind of strategic alliance. I think the approach needs to be on what's going to actually work, and form has to follow function.

So there are areas where integration isn't about merger but building better connections. A number of the CMHA branches in the province have developed some strong relationships with primary care to get at the fact that lots of people, especially with serious mental illness, tend to die 25 to 30 years earlier. The Windsor branch developed a satellite community health centre. CMHA, Durham, as you know, has a fabulous program that integrates primary care and mental health care. So I think we need to be thoughtful. It's not about structure, in some cases; it's about process and resources.

I think that's what the health links are about: how you can get people to work together. Of course, the challenge on health links is going to be, can process improvement do it all, or are there some real capacity gaps in the system? I would argue that I think if we're objective we'll see that there are capacity gaps.

I'll give you an example, and Kim Baker is sitting in the back, from our LHIN. We had meetings with the community support sector and the community mental health sector and North York General trying to find resources for people who were showing up in their emergency department. One of the case examples which typifies the capacity gap is that North York General brought to the table the case of an elderly Chinese woman who was living with her son and his wife, who was soon to have a baby. The woman had dementia. She wandered and she got violent at times. They had just brought her to North York General to say, "Here. We've got this baby coming and we can't cope with mom anymore." So we had this collection of people in the LHIN—community support service folks and mental health and addictions folks—and we were trying to figure out what we could do. One of the partner agencies stepped up, even though they don't provide services in Mandarin, and said, "Look, we could pick this woman up and take her to our day centre five days a week," which appeared to be a partial solution. Then there was silence, because there was no service, whether it was respite or otherwise, to deal with what would happen between 5 p.m. and 9 o'clock the next morning or on weekends.

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I think that as the LHINs do their work on health links, it will be really important to look at where the instances are, in fact, where we have to keep investing, as Camille and the Drummond commission said, in community capacity to reduce the reliance on hospital services.

Mrs. Christine Elliott: Great. Thank you.

The Chair (Mr. Ernie Hardeman): Go ahead.

Mrs. Christine Elliott: Another question? All right.

I was interested in your comment under section 4, community engagement and governance, speaking about the different tables, speaking about the administrative burden being high, "and without a clear provincial objective of how all of these initiatives interrelate, it can become unmanageable."

I'm wondering if you're feeling that you're missing something from the province, or the LHINs are, in order for them to be able to do their work, and what the concern is there, a bit more specifically.

Ms. Camille Quenneville: It's a good question. The feedback I had from some of our CEOs is that there's an expectation that they will sit at all of these tables, and it's a difficult thing to do. It's not that they don't want to be there; it's just very cumbersome for them to be there.

There doesn't appear, sometimes, to be an overriding plan in place. All of these are distinct efforts, and I think that's where some of the confusion is: We have to be here and over there at the same time, and we're not sure how all of this works together.

Mrs. Christine Elliott: Well, that has been expressed to us by others in the sense that it's important for each LHIN to be able to respond to local health needs, but that there is a lack of an overarching plan determining what the priorities are, because there are many, many priorities in health care. Do you think it would be helpful to have a more clearly delineated plan from the provincial level?

Ms. Camille Quenneville: Absolutely.

Ms. Marion Quigley: I think that once we see the implementation of the four-to-10-year plan, once it gets implemented, we'll have a better idea of where the priorities are, because right now everything is a priority, and we're all trying to be at the right tables to look at improving the system.

Ms. Camille Quenneville: And they're all worthy too.

Ms. Marion Quigley: Yes, and so what happens, for a community service provider, is that the table wants a decision-maker to be there. Well, there are only so many of us around, so if we know what the priority is—and I know the LHINs look at what the priorities are, through their integrated health services plan, so that's helpful, but there are also provincial strategies that are also coming down. So I think it's just to have a better coordination of the system.

Mrs. Christine Elliott: I would certainly agree with you in respect of years four through 10. We've had the focus on youth for the first three years, but I think we all want to know what the priority is going to be for the next few years. That's a very fair comment.

Ms. Camille Quenneville: Yes, absolutely. I think Tim wanted to add something.

Mr. Tim Simboli: Integration has become a bit of a flavour du jour for not only the LHINs and the Ministry of Health, but just about everybody in all levels of government. There are coordination and collaboration tables springing up very quickly, expecting the leaders of organizations to show up, and there isn't the cross-pollination or integration of these priorities through various different sectors, through various levels of government. I could be at three meetings a week, talking about

integration, and in the end there are no more services, so it has a an "organizing the deck chairs on the Titanic" feel to it.

It doesn't mean that the LHINs have to drop their priorities or defer their priorities. It just is a matter of integrating the priorities with the other things that are going on.

I might also say that the experience is different in every LHIN in this province. When we get together and we gather and start to compare notes—I would say there are probably no two LHINs that have had common histories over the last couple of years. They all have different personalities, different leadership skills. The priorities change if you happen to span a couple of different LHINs or you're in a couple of different municipalities. The need for meta-integration is really high.

Mr. Steve Lurie: Just a follow-up comment on that: It's actually a good-news story. Central LHIN and Toronto Central actually have worked together on coordinated access almost as an alternative to trying to merge organizations, to try and get the front door to work together. I think Camille Orridge spoke to that when she gave her testimony to this committee. It's actually quite a success story in that there is now one number to call, one application form.

Unfortunately, on the housing side, the waiting list has grown to 7,300 people from 700, when we first started the work. But the good news is that 42 people are waiting for ACT services and about 400 are waiting for case management. So it's one of those examples of when you talk integration, and you create a mechanism at the LHIN level, you also have to be able to go the next step and incent that by making sure the capacity exists so that you're not talking about just integrating a waiting list, but you're actually talking about creating better capacity and better access for people who require health care.

Mrs. Christine Elliott: Thank you, Steve. Those are all my questions right now, Chair.

Interjections.

The Chair (Mr. Ernie Hardeman): Questions?

Mrs. Jane McKenna: Thank you so much for coming. It was a good presentation here. I think the one thing that we heard over and over again was that—exactly what you're saying, right?—one hand is not communicating to the next. As MPPs, we'll say, ourselves, trying to get information for us is difficult enough, so I can't understand how anybody out there in the real world can get the information.

I get the fact that you've got subgroups, and you've got all these people and you're going to three meetings a week to talk to people, but if things aren't implemented, then what's the point of all this conversation?

I think what we've heard consistently is that we need to get our priorities straight, and put them down. I realize that one priority is as important as the next, but if we don't have some type of streamlining of where we're going and what goals we're going to, we're going to continue on the spin over and over again.

The other thing I'd just like to say is that I realize trying to get everybody in a room is very difficult, but in this 21st century, it is not impossible to get all these people together and talk through—there seem to be a lot of reasons why not as opposed to why we're doing it. So I think that's what I'd like to say here today. If you have any suggestions of how you do that, let me know.

Mr. Steve Lurie: I actually do, and it's not a suggestion I came up with. It's a suggestion that the LHIN Collaborative came up with when the 2011 mental health and addictions strategy was announced. They recommended use of the mental health and addictions networks in each of the LHINs to basically drive the kind of collaboration and priority setting that's required, because you can't do everything at once.

For example, I'm co-chair of the Central LHIN Mental Health and Addictions Network, and we recently presented to the provincial treasurer on what our priorities were. We had developed this list of priorities working with Central LHIN on their IHSP. So, just to give you an example, we came up with a list of more funding for supportive housing, continued funding for behavioural supports, continued funding for coordinated access projects, improving linkage to primary care, enhancing mobile response, and there's a list of others.

The point would be that the LHINs could engage with their mental health and addictions network in the context of, let's say, years four to 10 of the strategy and say, "What are the things we could do in two to three years? What are the things we could do this year?" Because you can't boil the ocean, but I think most of the mental health and addictions networks in the province, which CMHA across the province is part of, could provide that kind of programmatic advice to the LHIN. That way, it wouldn't have to be one size fits all. If emergency services is important, let's say, in Central LHIN but not in the South West, the mental health and addictions network can shape within provincial parameters.

Mrs. Jane McKenna: Thank you.

The Chair (Mr. Ernie Hardeman): Okay. The third party: Ms. Gélinas.

M^me^ France Gélinas: I'll start. We went back and forth. We both have questions.

The first question I want to ask—there was funding made available for mental health workers for schools. In my little brain, I always saw those workers going to your agency, but they didn't. They went through the community care access centre. So I will ask the three executive directors: What were the discussions that you had with your LHINs as to who was best able to offer that service?

You get to be the first one, because you're first on my list.

Ms. Marion Quigley: Our LHIN had no discussion with us. We brought it up with them and asked, what was the rationale? Because they were coordinated and looking at more than mental health—that mental health would also connect with primary care, with family—they felt that the CCAC was a better place to put the nurses.

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We actually brought all four CMHAs from the north to meet with our CCAC about it, prior to them starting

their job, and asked if we could help build partnerships with them, and we have. It has been fairly successful, I would say, up to now. The biggest downside I see is that there are not enough nurses in the schools. They're just meeting a small amount of individuals who need that support, but they are working collaboratively, the ones that we have in the north that I can speak to.

M^me^ France Gélinas: Sticking with the north—I still don't get it. You work with family physicians and you work with primary care at many, many levels. Why couldn't you have worked with primary care and family physicians at the school level?

Ms. Marion Quigley: We could have. That would be a question for the LHIN.

M^me^ France Gélinas: Okay. I'm going to go to Ottawa. How did it go—

Mr. Tim Simboli: I'm Ottawa.

M^me^ France Gélinas: Sorry. Toronto, then Ottawa—I'll just—

Mr. Tim Simboli: Toronto always gets the turns.

Mr. Steve Lurie: I guess it shows how truth travels. What we were told is that the decisions were not made by the LHINs, but that basically the ministry had decided that this is what was going to happen. After the fact, the CCACs actually have approached the mental health and addictions network, we've met with them and talked about how we might work together. But I think the issue is very much as Marion raised: It's a question of resources.

The other dimension of this is that there's a whole sector—the children's mental health sector—which is doing its transformation on its own. When you're talking about children's mental health and potential collaboration between the sectors, particularly around the needs of transitional youth, the LHINs actually can provide a useful table for those discussions.

In the instance of the mental health nurses in the schools, I know that our colleagues, certainly in Central LHIN, and I think in Toronto Central, were a bit perplexed about why there wasn't any conversation with them about how this was going to roll out. But I don't think it was the LHINs' fault; I think this was a decision made at the ministry level.

M^me^ France Gélinas: Okay. Sorry, Ottawa, you get to be—

Mr. Tim Simboli: It would be the same experience in Ottawa as Steve described: not a lot of discussion; it was kind of a command decision, it seemed, that came through. We didn't have an opportunity to debate it, and we haven't had much of a conversation since then about how it might roll out. We've done other things with youth and youth mental health, but it has not been associated with schools at all.

M^me^ France Gélinas: I'll start with Ottawa. Do you think your agency would have been a good host for those kinds of resources to roll out to the schools?

Mr. Tim Simboli: We participate in a network, and that network would have been a good host, and none of the people in that network are part of this. There's a thriving organization, the Youth Services Bureau of Ottawa, that we collaborate with an awful lot. They would have been instrumental in doing that sort of thing. As far as I know, they were never asked.

M^me^ France Gélinas: We are looking at making changes to the LHINs, so what kind of changes would need to happen? I'm not too impressed with what you're telling me happened on the ground. What kind of changes would need to happen so that things like this go to your mental health and addictions collaborative or network so that, next time, if there are resources, they are allocated in the way that the network has an opportunity to have input and influence? Any one of you can tackle that one.

Mr. Steve Lurie: I think Tim gave you the clue. The word is "network." It seems to me that the LHINs can make use of networks and they can help create networks where they don't exist. We've seen examples—the dual diagnosis initiative has rolled out over the last 20 years, where there was a dedicated professional to help staff a network, and then you build the linkages to services.

It seems to me that the LHINs have actually, to their credit, in seven years, changed the conversation. This is no longer what one agency can do on its own, but it's how agencies can act together and work together. So I think the encouragement for the LHINs to look at where they do need to bring tables together—I know, for example, that Central has brought the community support network and community mental health and addictions together to talk about quality issues.

It seems to me that you can be purposeful around networks and look at where it makes sense to have groups collaborate. For example, going back to children's mental health and the transitional age piece, that's not an issue that either the children's mental health group can solve on their own or the adults can solve on their own, so you actually need to create a table. But if you designate it as a network and you say to the network, "We're looking for your advice"—and in fact, at the beginning of the establishment of the LHINs, Kim's predecessor, Hy Eliasoph, came to our network and said, "The network is the group that the LHINs would look to on advice for investments." So it seems to me you can strengthen that role and build the collaboration at the program level, and also that the LHINs could see these networks as colleagues having to sort of take off their individual agency hat and work together to create a shared vision for where things need to be invested and how to roll out programs.

M^me^ France Gélinas: So from what you're telling me, am I right in thinking that, as legislators, we should make sure that if resources are going to be invested in a field that is covered by the LHINs, then we make sure that the LHINs have an opportunity to do their work of engagement in communication and consultation?

Mr. Steve Lurie: Yes.

Ms. Camille Quenneville: I just want to add to what's been said. I think this falls into the grey area that I referenced in my document around the housing example that I gave, but it's the same concept, where the Ministry

of Health is a direct funder and so are the LHINs. So in situations like this, it's a little ambiguous in terms of who's taking the lead.

I came from seven years in the child and youth mental health sector and was certainly there when that funding was provided, so I would concur with my colleagues that this was not a LHIN decision. It really was directly through that ministry, rightly or wrongly.

But at the end of the day, there is an appetite to engage and collaborate. If those dollars are flowed in such a way through the LHINs where it can go to a table in most cases and those decisions can be made with respect to service delivery, I think everybody benefits.

M^me^ France Gélinas: Okay.

Ms. Cindy Forster: Hi. Thanks for being here today. My question is very specific and it's kind of a follow-up to what Ms. Elliott raised.

We know there's a large number of inmates in correctional facilities in this province who have mental health issues or have a long history of a diagnosis of a mental illness. I had the opportunity last week to meet with a couple of nurses, who actually work in corrections, here at Queen's Park. They say that the ratio of a nurse to an inmate is 150 at a minimum and 250 to 300 at a maximum on a shift. Many of these inmates come out of a history of living in poverty, with no access to primary care. They may have multiple complex medical issues in addition to their mental health issues, and they have no access to CCAC funding or services. It's all done through corrections.

I have two questions. Are there any services available to these inmates with mental health issues, particularly, through CMHA? And if not, is this an opportunity to talk about some integration with respect to funding in corrections? Should that funding actually be through the Ministry of Health and Long-Term Care and filtered through the mental health system, as opposed to the corrections system?

Ms. Marion Quigley: I'll start. Right now, funding for supports for individuals in jail is provided through the LHIN through the Ministry of Health. That is discussed at the human services and justice provincial and regional tables. Most CMHAs that have court diversion programs would have a release-from-custody worker. They would have case managers, court diversion workers, and they do work quite closely with the social worker and the nurses in the jail. The capacity is more than the resources that we have, and it is an issue. It's an issue around medication for inmates when they first get incarcerated. So there are many issues around the jail system.

Ms. Cindy Forster: I think the other issue that they raised for me was the fact that they're not reporting in the corrections system to anybody with a medical background; they are reporting to a military regime type of superintendent. Right?

Ms. Marion Quigley: Well, there is a superintendent, but there are psychiatrists. I can speak to the Sudbury experience, and there are psychiatrists and a family doctor who go into the jail. The nurse works quite closely with them, and so do the staff of the CMHA program, for court diversion. I'm not sure if my colleagues can expand.

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Mr. Steve Lurie: I'd like to do it in two respects. One is about the services available. As Marion said, CMHAs and other community mental health providers in the province—and certainly in Toronto and Central LHIN, there's a range of services available. There are safe beds, or what we call crisis prevention beds. People who don't necessarily need to be taken to hospital and shouldn't be taken to jail can access those beds, where there's a comprehensive plan and stable housing for a month. But it's only a month, so if there's no housing at the other end, you've got a problem.

We operate in two of the five courts, but we lead a court support consortium here in Toronto. Again, the same issue: People are able to access services when you do have a court support program, but then it's what's behind that. So if somebody has, let's say, a concurrent disorder and there isn't sufficient concurrent-disorder capacity, you've got problems. The mental health and justice housing that was funded from 2004 to 2006 in Toronto has been a tremendous success: close to 500 supportive housing units. We've done an analysis where the average length of stay of people who were going through the justice system with mental health issues is four years of successful tenancy, but those beds are now full. You can't get at them. So I think there are services, but I think the other piece is that the demand is far greater than the services that are available.

Greg Brown from your part of the province did a wonderful study a few years ago where he looked at the incidence of mental illness in the Ontario correctional population. He looked at 300 in-patients, and what he found was that about 40% of the inmates, in fact, had a diagnosable mental illness, but only about 6.9% were serious mental illness. However, something like 28% of a predominantly male population had reported being victims of abuse, 60% of the total population had been victims of abuse or had observed abuse, and 66% had a concurrent disorder.

I think the jails are really under-resourced, and that's not where you should be getting your mental health treatment. Paul Kurdyak, who's doing the work for ICES—we met with him recently. He said he has been looking at the OHIP records of people in the provincial jails, and what he finds is that, for many of the people with mental health problems, the first time they see a psychiatrist is when they're in jail. That's not a LHIN problem; that's an overall resource problem.

The other part that I think is something that, as legislators, you could recommend is that—even when the program services are available, one of the problems that we see across the province is access to physicians and psychiatrists. Many psychiatrists don't want to follow somebody clinically if they've been involved with the justice system. They seem to think it's forensic.

There's a good-news story on the forensic side: Both Tim's branch and my branch have been partners with the

Ministry of Health in what's called the transitional housing program for patients who are high-need, not so much in terms of risk but in terms of activities of daily living. These are people who've been in psychiatric hospital forensic units for a long time. We've been able to successfully integrate them into the community. This is now spreading province-wide, but again, once you finish your 18 months in transitional housing, you need some other housing to live in.

I think there's lot of evidence of the fact that the Ministry of Health's initial investment, in the earlier part of this century, in mental health and addiction programs focused on the population who was involved in the justice system was a good thing. It's just that we need a lot more of it.

Ms. Cindy Forster: Thank you.

Mr. Tim Simboli: Could I throw my two cents in?

Ms. Cindy Forster: Yes.

Mr. Tim Simboli: There's an overwhelming problem that underlies all this, and that's the criminalization of people with mental illness. As Steve says, sometimes the first time they get any help at all is after they've broken the law. The other thing is that we've got to remember the sheer volume of people who are clogged in the system. There are almost as many people on remand as there are who have been sentenced in the system. These are folks who are clogging up the system constantly. Our failure happens before the doors of the courtroom. If our successes could happen before the doors of the courtroom, then everybody is going to benefit. It's going to reach a tipping point where that, in fact, can be resolved.

Ms. Cindy Forster: So if the resources were at the front end, we wouldn't experience the expenditures that follow?

Mr. Tim Simboli: Absolutely. Yes.

Ms. Cindy Forster: All right.

M^me^ France Gélinas: Do I still have time?

The Chair (Mr. Ernie Hardeman): Oh, you have plenty of time yet.

M^me^ France Gélinas: I'm on the top of page 4, just before the heading "Funding." I don't know if your document is identical to mine, but the second-last sentence: "There are currently far more ministries than there ever have been focused on mental health and addictions, and there are structures and processes within government that could link them together. They need to be utilized."

Could you elaborate on this with a view of, we are here to review the LHINs? Do you see a role for the LHINs regarding what you had stated in there?

Ms. Camille Quenneville: Yes, although perhaps somewhat indirectly. What I think we're referencing here specifically is if you looked at the machinery of government and were able to put all of those ministries that have some involvement in mental health and addictions together regularly to provide perhaps more direct engagement, if you will, on where funding should go. It's a little indirect to the LHINs, in that it's more an opportunity—given that there are nine, at last count, ministries—to put them in a room together on a regular basis to coordinate the services a little better from a provincial perspective before funding flows to the LHINs so there is perhaps more clear direction. Again, that can be done a number of ways.

M^me^ France Gélinas: I saw that you opened up your remarks by saying that you're not interested in Mental Health and Addictions Ontario, which was to bring those—there were 11 at the time—nine ministries together so that we give mental health and addictions a home, the idea being that those nine different pots of money that end up in our community funding different things are often at cross-purposes and have silos of their own.

Ms. Camille Quenneville: I think the point really was to say that we don't think we need to build another structure that would be a larger overriding mental health and addictions structure. I think there's a lot that can be done to coordinate services better within existing structures. Whatever money you would want to spend on putting that together could be better spent providing direct service.

M^me^ France Gélinas: So you're saying that you think that it would be sufficient for those nine ministries to have a meeting together every so often—

Ms. Camille Quenneville: Right, but I would think it would be something more significant than having a casual meeting together. I think what we're contemplating is—and again, it's not just our organization but our community partners who have come together to think about this: Is a cabinet committee an option on mental health and addictions? Is there a Premier's council? There are lots of things that we could look at, the idea being that—I have to tell you, I've sat through some of the other presenters before this committee. This was before Christmas time. I recall one of the presenters referencing, kind of with anguish, that there are nine ministries now, like: "Isn't it awful?" As somebody who has been in the field for some time, although not nearly as much time as my colleague Steve, I wanted to cheer from the back row because I thought that it was a few short years ago that we were trying to get two other ministries interested in mental health. If it's on the agenda, let's put it on the agenda formally and build a structure of government around what the priorities are and how we want to proceed.

M^me^ France Gélinas: Given that the treatments for people with mental health and addiction are often based on the social determinants of health and go way beyond the Ministry of Health but yet your funding comes to you through the LHINs, would it make more sense to broaden the mandate of the LHINs so that other pieces of government that support the social determinants of health that your clients depend on also are coordinated by the LHINs? Give them, not necessarily funding, but authority to plan?

Ms. Camille Quenneville: My sense is, not necessarily an expansion of the mandate of the LHINs. I do think—having worked in government myself, and I've seen it happen with great success—it's a matter of ensuring that the internal structures of government are

there. I quite agree with you: It is much broader than Ministry of Health funding.

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But if clearer direction comes from the province and it's done through a process where all of those ministers are at the table, and potentially with an advisory committee of other community partners who raise these issues on a regular basis and inform a cabinet committee or another type of vehicle, I think we could have great success with that.

Do my colleagues want to add anything?

Mr. Steve Lurie: Yes. I think actually there was a precedent. The mental health and justice funding that rolled out through the LHINs between 2004 and 2006 was driven by a multi-ministry table. Then the LHINs and actually the ministry regional offices which preceded them rolled that money out. So I think there's the notion of what the Mental Health Commission calls in their national mental health strategy a whole-of-government approach, which I think is absolutely critical so that all the departments involved have a plan and decide how they're going to work together.

Certainly there has been experience in the UK in what they call pooled funding. We had a small example of that with the mental health and justice funding, although it was the Ministry of Health that had to come up with the money, as opposed to the other ministries. But the point is that you could have a pooled-funding approach and then, if it made sense to administer it locally through the LHIN, you could do that.

We did some work through the Mental Health Commission looking at the housing side. Ironically, it was the province of Newfoundland that had a one-government-window approach. It didn't matter what target group you were doing the housing from; there was one place you went to get at least the housing dollars that you could then match the service dollars to.

So I think it's this notion of building on a whole-of-government approach, a pooled-funding approach, and then stepping back and saying, "Are the LHINs our vehicle at the regional level or do we need something else?" because in some cases, for example, you've got to bring in the municipalities.

While we're on housing, I wanted to make a pitch, just to follow up on Camille's earlier remarks. The LHINs are to be commended. Toronto Central and Central put money out for housing first. That was based on the experience with the Mental Health Commission's At Home–Chez Soi project, which showed that you could improve housing outcomes for people, that 70% of people were able to be stably housed, as opposed to 30% who got treatment as usual. But the problem is there's no money for rent supplements. There's no money for housing. So how can you do housing first without the money to rent the places or, in parts of the province where there's no rental market, make sure you can at least access the housing? That's where that whole-of-government approach is so important, that the service dollars and housing dollars come together somewhere.

M^me^ France Gélinas: You're going exactly in the direction that I wanted you to go. Maybe I'll pull in the other two. If you look at the integrations of the different parts of government or the whole of government, as you are calling it, to better meet the needs of the people who have mental health and addiction, who live with mental health and addiction, it—I have a hard time spitting it out. You said, "Let form follow function." So is it more important that we focus on bringing the whole of government, bringing this cabinet committee or whatever it's going to be called—that we bring all of the different ministry players that help people with mental health and addiction, and this is housing and poverty and jobs and health care, or is it more important that you be integrated with hospitals and long-term-care homes at the LHINs level? I'm trying to see how this fits. We've been on this long enough. Almost every community support service agency loves the LHINs. They are respected; they are talked to; they are listened to; they are participants. We get that.

I'm a step further than this as to, to meet the needs of your client, you need way more than health care to come together. I don't see it happening through the LHINs. You seem to be agreeing that a big part of it will come from outside of health care.

How do we marry the two? What's the place for the LHINs? Why are you under the LHINs when you maybe should have something that focuses on mental health and the social determinants of health to help the population you serve?

Who wants to tackle this? We'll start with Ottawa.

Interjections.

Mr. Tim Simboli: Thanks. I feel like I'm in school again, and I was just called upon to answer a question I didn't study for: "I didn't know this was going to be on the exam."

The things that work in my world are making sure that the work gets harmonized. It doesn't have to be brought together all at once in one grand, super-organized kind of way. I think—borrowing on complexity theory—it's chunked. It's a little bit here, a little bit there.

The two things that I would say are probably guiding principles for this are that in my world, if the integration between organizations only happens at the ED level, it doesn't work. If it only happens at the front-line level, it doesn't work. It's got to happen at multiple levels.

The second part of it is that the funding stream, the government stream, the folks who feed us the money to do the good work with, need to be every bit as integrated as they expect us to be on the service side, and that's not happening.

Where it does happen, there are wonderful things to show for it. There really are. There's success out there. It's not like we're wishing for things that, "Maybe this will work and let's try it. What have we got to lose?" There are examples of coordinating bodies that actually work. They don't have to be universal or across the board, but they do need to have some involvement at every level, as a whole-of-government approach, starting

and working its way down. I think it can be as simple as sharing priorities and sharing the new things that are coming out so that you don't have to cover all of the existing stuff.

Start someplace; start with the new stuff. What are the priorities for funding coming out of one department compared to another or one level of government compared to another? I think it's almost that simple at this stage.

M^me^ France Gélinas: I'll go to the north—your take on it. Is this what I call horizontal integration, where you have housing and income and mental health, correctional services and Attorney General—all of this brought together, or this way, where you have the LHINs and you get your health funding like the hospitals, the long-term-care homes and the mental health?

Ms. Marion Quigley: To me, it doesn't matter where I get the funding from. I just need the funding to provide community supports. So whoever wants to give it to us, we're here. That being said, you need to have a system that coordinates the work, but then you also have to have the services on the ground that can implement, so that there's change for individuals. Whether the money flows from the LHIN—we have mechanisms, I would say, across this province, with CMHAs, where we're talking to each other.

From a community perspective, I think everybody does talk well together. We have our differences once in a while, but we're looking at what is the best way of providing service to the system. Where it breaks down is, we don't have enough service capacity to provide the housing supports or to provide case management. We can do lots of talking, but we have to have the programs to implement.

Looking at those multiple ministries from a larger scale helps to find out what everybody is doing, because you need to have direction to come down to implement.

The Chair (Mr. Ernie Hardeman): Speaking of talking together, we're going to let the government participate in this conversation. It's going to the government: Ms. Jaczek.

Ms. Helena Jaczek: It'll be a continuation of the conversation. I'd like to start off with Drummond's recommendation around integration, acknowledging totally what you've said about forced mergers not necessarily achieving the benefits that instinctively one assumes there are going to be savings at some level—certainly not at the front-line level, possibly at the ED level if you're going to merge two organizations, though often not. Often there's one ED and one assistant ED in merged organizations.

I think what Drummond was getting at was that it was a logistical problem for LHINs to put together service accountability agreements with so many different agencies. As I think we all freely acknowledge, there has been quite a bit of concern that the LHINs are an administrative, bureaucratic body with excess administrative costs to the system as a whole. So it struck me that that was more the argument from Drummond's recommendation, that it would simply be so much simpler to manage the system if there were fewer of these agreements. Do you have any comment on that?

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Mr. Steve Lurie: Yes. I think you could get to fewer agreements without necessarily merging organizations. In fact, I think it's really important to do the due diligence on most of the mergers in the public sector. The ceiling becomes the floor, and so, often, you get increased wage costs by the partners coming together and you actually don't add services. Camille laid out the principle: Is it going to be better for people? At the end of the day, if you're talking about a merger, it's not how many organizations a LHIN can manage; it's whether more people are going to get better service. If you can argue yes and that a merger is the way to do that, then you proceed.

But I think that it would be possible—especially since one of the areas that I think the LHINs have started to look at is, you've got the regional table at the LHINs, but you've also got, increasingly, especially with health links, local tables that are emerging.

So it would be possible, for example, in Scarborough or North York, for the Central East LHIN or Central LHIN to have a memorandum of understanding or an M-SAA with all the partners about what they're going to provide in that locality. You'd have to build a process where people would learn to negotiate together, but I think you could reduce the number of M-SAAs by looking at sector-based work.

You could, if you wanted to keep it at a LHIN level, conceptually do an M-SAA with the mental health and addictions network, where people could still specify their units of service. One of the challenges that I think the LHINs face is that they actually have fewer resources than the Ministry of Health regional offices that preceded them, and they don't have an ability to do program management. So I think that there are some creative ways where the LHINs and their partners could figure out how to have fewer M-SAAs to administer but better service.

I think that there is also lots of work that is now going on. Camille referenced in her brief the collaboration that's going on with the LHIN/M-SAA table around improving data quality. So I think that if we start to look at what the critical things are that we should measure and at what levels we measure them, and how we resource the system appropriately, I think that there are ways that you could at least be more efficient.

But I don't buy the notion that having fewer organizations necessarily reduces the complexity of the system, because you still—for example, in my organization, a manager of a case management program supervises 15 staff. That's about what it should be, and I think that's the other side of this. We've sort of built structures, but you need to look at what needs to be in place for the service you're trying to operate. This is where, for example, the coordinated access project that I've mentioned previously—that brings together 31 supportive housing organizations and at least another 20 to 25 case management and ACT organizations, including CMHA.

We are all signing—we all have memorandums of understanding with the coordinated access group here in Toronto, so there's no reason why you couldn't build on that and say, "Okay, what services are you going to provide?" and they could report on our behalf to the LHIN. We'd all be signatories.

Ms. Helena Jaczek: So in other words, a more flexible way of structuring those service accountability agreements.

Mr. Steve Lurie: Yes.

Ms. Helena Jaczek: Now, since there are quite a few members from the select committee on mental health here, of which I am one, the reason, of course, that we did suggest Mental Health and Addictions Ontario was because, since time immemorial, we've had all these ministries involved in mental health. They've been given every opportunity to have some sort of structured meeting to bring the pieces together, and it has never happened. Our recommendation, definitely, was to, I think, challenge the government, to say, "This has got to work."

Since we produced our select committee report, have you seen any more efforts between all of the ministries to work together? It has been two years—actually, it was 2010; three and a half years.

Ms. Camille Quenneville: Yes; it's hard to believe how time flies.

We have. I've seen concrete examples of the ministries of children and youth services, education, and health coming together very regularly, along with the Ministry of the Attorney General. We work very closely with many ministries because we have such a broad base of policy work that we do. So it's certainly better than at any time that I recall. There's far more collaboration.

Mr. Steve Lurie: Especially on the human service and justice file. There has been a real effort on the part of the Ministry of Health, as the lead in that, to work with the Human Services and Justice Coordinating Committees, both provincially and regionally. For example, the police project that they just completed was a joint venture. I think those are the kinds of things that can be built on.

Back to our earlier discussion: If you had a whole-of-government approach to the next iteration of the mental health strategy, and you said, "In the next three years, we're going to focus on housing, employment and concurrent disorders," then you would bring together, hopefully, the relevant parts of the system, both at the governmental level and then, ultimately, at the community level.

If it was going to be housing and homelessness, you would certainly have the mental health and addiction folks who are involved in that area, but you might also be involving the municipalities and you might also be involving the LHINs, and then there could be a decision made about, "Is it a pooled-funding envelope that we'll ask the LHINs to administer, or will the money go to the municipalities, and the LHINs will contribute their share through that mechanism?" because I think there's no perfect structure to fund.

What my colleagues have said is that you need to, at the governmental level, if there is going to be a 10-year strategy—what are the priorities? Importantly—and the WHO did some research on this—jurisdictions that didn't set targets and didn't allocate funding didn't meet their objectives. If you come up with a mental health and addictions strategy, saying, "We're going to do all these things," but don't specify the money available, then you won't hit your targets. But if you did come up with a plan with targets and funding, then you'd have the flexibility, as you mentioned earlier, to say, "In this instance, should we actually ask the LHIN to take on the convenor role, or is this a better job for the municipality because they have more action in it?"

I think the important thing is to get away from the siloed behaviour where the municipality would say, "That's the LHIN's problem," and the LHIN would say, "No, it's your problem in the municipality." There are areas, for example, for people with complex issues that we're going to see in the health links where the CCACs and the mental health sector need to be able to come together to deliver the right range of services, because the mental health sector isn't funded for personal support workers, but the CCAC envelope provides that opportunity.

Ms. Helena Jaczek: Did you have something?

Ms. Marion Quigley: I just wanted to add that in the last year we've seen in the north a real increase in the youth ministry bringing the school boards, the CCACs and the adult mental health system together to work on collaborative projects and to really look at how we can work better together and transition youth into the adult system, so I have seen an increase there.

Mr. Steve Lurie: Again, because I think it's also important in your review to look at the things that have worked well: The behavioural supports initiative that the LHINs and the Ministry of Health rolled out for seniors with behavioural disturbances and dementia is actually one of the best examples of that focused collaboration. What happened was, the ministry and the LHINs developed a provincial strategy and then, in each LHIN, they pulled a series of partners together to both deliver the service and implement a quality improvement approach as they go. While I'm sure the people who were involved in that initiative would say they need more resources, they also can tell you that the resources were targeted appropriately and that they have learned from the things that didn't work. So this kind of, "This is our project for the next three years, here's the money attached for it, here are the partners that need to come together"—those things work really, really well.

Ms. Helena Jaczek: If we could just turn to resources, our wonderful researcher Carrie has put together some numbers for us. When it comes to the Central LHIN, for mental health and addictions she has been able to determine that there are some 661 people actually working in mental health and addictions, compared to Toronto Central with 1,794 employees. Now, that's a threefold difference, and I would hazard a guess that in the Central

LHIN, most of those workers are actually within the Toronto portion of the Central LHIN, the North York portion.

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How are you as an association looking at these types of discrepancies across the province in terms of resourcing and hopefully advocating to have some sort of equity of opportunity to access those services? What sort of table do you use to do that?

Ms. Camille Quenneville: Well, I speak directly to government, elected officials, and senior bureaucrats. It's generally in a context not specific to staff in LHINs, to be quite honest, but rather more global figures around our funding not being nearly as high as it should be. So in our report, thanks to Steve, we reference the fact that the Mental Health Commission of Canada indicates we should be spending 9% of our health budget on mental health and addictions, and we're spending 3.2%. We don't tend to get into the nitty-gritty of how many staff or what's happening in each independent LHIN, but rather to say that from a provincial perspective there are not nearly the resources that there need to be—

Ms. Helena Jaczek: In total.

Ms. Camille Quenneville: —in mental health.

Ms. Helena Jaczek: I'll have one last question, and then my colleagues, I know, want to jump in. When you have a client attend one of your agencies, do you find out where their place of residence is, and is that reported in any way to government, to the LHIN, to anyone?

Ms. Marion Quigley: Not to the LHIN, but we keep it within our documents, and we can show the LHIN where we have capacity, where there are individuals living, like in the downtown core or in the southern part of the city. Steve?

Mr. Steve Lurie: Yes, we can track the number of people from Toronto Central LHIN who use our services, the number of people from Central and the people from Central East, because we provide in Scarborough. I would make a point that, for example, most of the resources in Toronto are concentrated downtown, right around here, not in North York, not in Etobicoke and not in Scarborough. So even within a municipality like Toronto, you've got huge, huge resource gaps.

I think the critical thing is to start with the recognition that one in three people with a mental health issue is fortunate enough to get services. You've got basically six or seven people out of 10 who don't get services at all. So when we're talking about how many staff should be delivering the services, we have to look at, what would it be like if our goal was to meet the needs of 70% of the population rather than 30%?

Ms. Soo Wong: Thank you very much for your presentation. I'm here also on behalf of my colleague who had to leave early. We both have similar questions dealing with mental health nurses in our schools.

If I heard the presentation correctly, you commented on the fact that the ministry, all the LHINs, never consulted your association when it came to the rolling out of the $257 million when it comes to children and youth mental health in the system. So how do we improve it? Because at the end of the day, that's what this committee is charged with: to improve the system. Consistently, we heard that across the city of Toronto we have five LHINs and now multiple bodies going in, and yet we're not getting enough services from the mental health nurses in our schools. So can you suggest to this committee how we improve that? Because very, very clearly, your agency, being the lead agency when it comes to mental health, has not been consulted. How do we improve that delivery? We have funding, yet it's not getting to our front-line young people.

Ms. Camille Quenneville: Right. Our understanding is that the Ministry of Health directed those dollars specifically, and it didn't go through funding for the LHIN. So as a result, that left out processes which exist around the province in communities where those collaborative relationships come together and decision-making is done about how to carry out specific service. So to answer your question specifically, let's just erase the grey area where the Ministry of Health provides that direct funding in those instances and instead provide it to the LHIN so that it can remain in the existing processes.

Ms. Soo Wong: Right now, the LHIN is responsible for the funding, but it's going through CCACs, not through public health agencies across Ontario. The concern that we have consistently heard as MPPs in our area is the fact that the public health nurses are in our schools, yet they don't have funding to deal with this mental health piece. So I'm asking you, as the expert in the field, how do we improve the delivery? Because very, very clearly, the CCACs are not able to get into the schools, into the classrooms, to support young people. How do we improve that?

Mr. Steve Lurie: First of all, I think in that particular initiative there was a limited amount of money and they were looking to get it out quickly and they felt that the CCACs had the infrastructure, so the decision was made. But I think if you step back, it's a dialogue with school boards about, "What are your mental health needs? What kind of services do you need on the ground?" and looking at what is the experience in other jurisdictions about that kind of delivery—

Ms. Soo Wong: The school boards weren't even consulted.

Mr. Steve Lurie: Well, that's my point. You have an opportunity to improve these kinds of approaches. One of the nice things about innovation is that most of the time you fail and then you learn from it and you scale it up and you try to do things better. I would argue in this instance, if there have been gaps in the mental health nursing in the schools, it's a good opportunity to talk with the schools about what went right, what went wrong, look at what other jurisdictions have done. And sometimes you need benchmarks. If there's a jurisdiction that says, "Well, actually, for every thousand students, we need one nurse," then that becomes your target.

I think what happened here was there was a decision that it would be a good thing to put some nurses in the schools, but some of the mechanics of how it might work

and the consultations about the best way of doing it didn't happen. But I don't think it's too late to revisit that with the sectors involved to say what would work.

At the same time, there was money, as Camille knows, given to the children's mental health centres. Many of them are working in the schools as well, so there could be an opportunity to say, "If our goal is to improve school mental health service, what's gone right about the past initiative over the last three years and what could be improved?" and to encourage local communities to come up with plans.

Ms. Soo Wong: I also have a question on page 5 of your report—as a matter of fact, several questions.

You talked about "Funding transparency"—that's the heading there—and the last point that you commented was, "This points to the need for better coordination more than anything else—strong partnerships must rely on healthy communications" etc. Can you be more specific when you talk about better coordination in terms of the funding transparency?

Ms. Camille Quenneville: Sure. I think with that point, we were referencing some feedback that we had from one of our branches where they had had a number of very successful programs. Not surprisingly, within communities there is a lot of competition for dollars. New programs start up, and funding is stopped for existing programs and given to new programs, so there doesn't seem to be a lot of coordination in terms of how those decisions are made. The feedback we received was that if that was a somewhat more transparent process so that the agencies could better plan in terms of service delivery, that would be a positive thing.

Ms. Soo Wong: The other question I have is that on page 6, you talk about the inconsistency of definitions.

Ms. Camille Quenneville: Right.

Ms. Soo Wong: Can you elaborate for the committee on this whole clarification? If there are challenges between different LHINs in terms of interpretation of the definition, does your organization centrally write to the ministry to ask for clarification or do you get stuck in a local LHIN to get it interpreted?

Ms. Camille Quenneville: Well, I think Tim made the point earlier that a lot of the LHINs—when we come together as an organization, as we do regularly, and we talk about the direction the LHINs have provided, very often it's quite different. The example cited here is that when we talk about the administrative part of our budgets, in some cases the LHINs would say that your rent is included and it would be a higher percentage of your budget. In other cases, the rent was not included and it was a ridiculously low, frankly, part of the budget that was allowed. It just struck us that if there was some consistency in terms of how all of the LHINs were defining these things, it would be so much easier for our organization, to say nothing of all the other community-based organizations, to share best practices, to come together, to collaborate more easily.

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Ms. Soo Wong: Has this been brought to the ministry staff about this confusion—

Ms. Camille Quenneville: Yes, absolutely.

Ms. Soo Wong: —and were there changes made after you brought that to their attention?

Mr. Steve Lurie: It has actually been brought to the LHIN/M-SAA table, and there's a group now that is looking at what should be the amount of money spent on administration and how it should be defined. We were quite happy at that table, where there was an agreement that the LHINs would have a look at it and then bring it back to us for discussion.

But I think the more fundamental problem is—former Minister Smitherman asked David Reville about five or six years ago to look at this myth about too many agencies and high administrative costs. He came out with a report that actually encouraged partnering and actually demonstrated that there was a lot of partnering going on at the service level, but that most community organizations didn't have much in the way of infrastructure. So the assumption that our administrative costs are too high is something that really needs to be tested.

For example, my organization—I've got about 300 staff and two people to run the IT, and that's a real challenge. I've got one and a half people for human resources. I think we need to be very, very thoughtful about how we define administration and, for example, what it should be used for. When money gets tight, the first things you start to cut are things like staff training, but, in our field in particular, the ability to train staff and encourage their learning and help them with career development is critical. So I think not only consistency in definitions but a thoughtful approach to how it's going to work is very important.

Ms. Soo Wong: And then my last question: I notice that in your entire presentation, you never alluded to the diversity of the province, the challenge of delivering diversity and so many different groups across Ontario. So I want to hear your comments and/or your suggestions, because one size doesn't fit all—

Ms. Camille Quenneville: Yes.

Ms. Soo Wong: —and definitely we see the concerns across my riding in Scarborough but also across the greater Toronto and Hamilton area in providing adequate services to the diverse community. Steve, you talked about the Chinese community, but there are multiple ethnic communities in the province. I was just surprised in your presentation that you didn't make any effort to talk about that.

Ms. Camille Quenneville: Yes.

Ms. Soo Wong: If you could elaborate, that would be really helpful.

Ms. Camille Quenneville: Well, I appreciate that, and I appreciate the feedback. I can tell you that we have, amongst our small staff, one full-time person who works on health equity policy, and we have considerable work that we've done in this area that has educated and helped to provide service for multiple organizations.

We're actually seen as leaders in this area. I can point to probably 20 areas off the top of my head that I didn't get into today because, again, our policy work is so

diverse. So, while you're quite right in pointing out that that was absent, this wasn't really an attempt to look at the diversity of the policy work we're doing.

That said, I can tell you that, as an organization, the Canadian Mental Health Association, Ontario division, has undertaken significant work in terms of our own board, diversity and equity, and we hope that serves as a guide as well.

I'm really very proud of the work that we've done in this area. Our staff person Sheela Subramanian, who does the work, is well regarded across the LHINs that she has worked with, and has provided great knowledge transfer in this area.

Mr. Steve Lurie: I think, since you did mention Toronto, we know that we're in one of the most diverse cities in the world. Toronto is actually a majority minority city, where over 50% of the population are visible minorities. So our branch, for example, has a program that is targeted at the Tamil community, the Somali community and the Afghan community. We've just engaged Dr. Lin Fang at the faculty of social work to do a review of it, which shows that actually their ability to access targeted case management services using case aides from their community really had a good impact on outcome.

We've been very fortunate with the LHINs. For example, in that access project I mentioned earlier, we did a health equity impact assessment as that was being developed. We recognized that, for example, to assume that the Somali community or the Chinese community or the South Asian community would necessarily go to some central access point to try and get services—so we built in that with organizations like Across Boundaries and Hong Fook and ourselves that had dedicated programs, there would be abilities to build those access points within communities. So I think you're absolutely right; it's a critical issue.

The LHINs have also been quite helpful in funding interpretation services. Both Toronto Central and Central have made money available for us actually to increase the language capacity both on assessment and involved in service delivery. So while it wasn't mentioned formally in the brief, it's top of mind for many of our organizations.

Ms. Marion Quigley: I'll just add, too, that I would say most branches in the province of Ontario also look at it. I can speak to Sault Ste. Marie looking at having their brochures interpreted into Italian. In our community, it would be French and English and aboriginal.

The Chair (Mr. Ernie Hardeman): Three minutes left. Mr. Colle.

Mr. Mike Colle: Steve, I think you mentioned something about an initiative with the police, I think taking place in Toronto, in terms of intervention with mental health situations. Has there ever been a quantification of how many dollars the police are using in terms of their resources in being first responders to mental health situations?

I've mentioned this before: I talked to my local superintendent. He said that the number one cause of calls in his division are now the calls for mental health issues or addictive behaviour issues—drug addiction etc. Essentially, if he goes through his logbook, he can see that it's basically repeat situations where people with personality disorders or mental health issues, that are on remand or whatever it is, are almost the number one—it's no longer the domestics, and it's no longer the violence on the streets; it's basically mental health issues.

Mr. Steve Lurie: Well, I think two years ago the Ontario chiefs of police had done the calculations, and they said that they don't want to be the first responders, and this last summer the Canadian chiefs of police said the same thing, so that's a statement about the lack of mental health services and the gaps on the ground.

But I know in Toronto, Mike Federico, the deputy chief, has tabled some interesting perspectives about the number of calls. Toronto police get, I think, three million calls a year, of which 20,000 relate to mental health, and they end up apprehending about 8,900 people a year, so in some divisions that would be a lot of calls, depending on location. I haven't seen the comparison with other types. Deputy Chief Federico simply identified the number of mental health calls they get.

I think everybody would agree that when mental health services aren't available to you and you're worried, or you don't even know what mental health services are available and you're worried about your safety, you call the police. For example, in Toronto, we now have had an expansion of the police crisis intervention teams, and most of the divisions will have them, but they're not available 24/7, unlike COAST in Burlington and Hamilton.

Mr. Colle, it's a big issue, but I think you have to come at it in two ways: One is the lack of resources in the civil system, which then have people defaulting to the justice system because they're scared and they don't know who to call.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time. Any further questions? Ms. McKenna.

Mrs. Jane McKenna: The beauty of this committee is to have your recommendations, and then we get together, obviously, because it is about being patient-centred—and doing what's best for the patient, ultimately, in the end, is what we're trying to get to the bottom of here.

I guess I struggle at times, because if we're not part of the solution, then we're part of the problem, so I want to go back to two questions. Ms. Wong said that the school boards weren't consulted and, Mr. Lurie, you said that you obviously learn from things if they're not done properly the first time. I guess my question to you is, where is that information put so that next time we don't do it again? I guess we're always learning from the mistakes that we make, unless there's something that we're implementing to change it the next time around. Where does that information go, besides saying that here? Who gets the recommendation that the school boards weren't consulted from CCAC?

1650

Mr. Steve Lurie: Well, I would think that if that's been a concern you've heard, not just from us but from others, if that becomes part of your report, the operating ministries would obviously have to respond to it, and should respond to it. I think if you were to recommend that they revisit and evaluate the initiative of the last three years, and what's gone right and what hasn't gone right, and how it could be improved and come up with improvement plans—I mean, that's what quality improvement is all about.

It's always easy to catalogue all the problems, but I think it's also important to be able to identify the things that have gone well. So with respect to the LHINs, I mentioned the behavioural supports program, which was really a success; and the fact that the LHINs have been able to develop and support mental health and addiction networks that they can build on. But I think, again, we talked about whole of government. Hopefully, your report will be read by the government of the day, and then the things that you're recommending in terms of improving the system, the various ministries that need to be involved in the implementation—I think that the important thing that Camille's remarks talked about, and that we've tried to address, is the importance of engaging the community locally, to make sure these things actually happen, because if it's just a report to government—

Mrs. Jane McKenna: Yes—

Ms. Camille Quenneville: If I could just respond in part, as well—I appreciate your concern around this, and I think it's worth noting that the Ministry of Health is actually reviewing the process under which those dollars were provided and the program itself. I know that was built in when it was originally announced, that it would be reviewed. I think they've had considerable feedback and questions about how some of that was rolled out locally. So I think that they will have that information available to them.

Mrs. Jane McKenna: I guess, when we're talking about the cabinet committee that you spoke about earlier and looking at the inefficiencies, I have a two part question here: Who is saying what the inefficiencies are, and how effective are you finding that with the gaps and the overlay that there is?

Ms. Camille Quenneville: I'm not sure—

Mr. Steve Lurie: Inefficiencies in relation to?

Mrs. Jane McKenna: Well, if there's gaps and duplication, who is saying what gaps and duplications they are? I guess my question is, there's lots of information here, and the most important thing is that we have to look in-house first, because ultimately in the end, if there isn't any more money, the people that are going to be affected are the people on the front line. Right? Especially in government—it's the exact same thing here—when the money's gone, you've got to look at in-house, to figure out where that money needs to be to make things better, so that people are still getting the services that they need. If you have the cabinet committee identifying the gaps, what is actually happening with that information? So you can see where you've got duplications, so you can look to see where money is being wasted, I guess, is my—

Mr. Steve Lurie: I'd first challenge—I mean, there's a lot in rhetoric over the last 20 years about all the duplication in the sector. First things first, we can estimate based on the health indicator tool—it's not an estimate, it's actual: Last year, 441,000 people used community mental health and addiction services, which is far more than used hospital services. But if you extrapolate from the Mental Health Commission statement of 6.7 million people living with mental illness, that would suggest that there are probably over two million people in the province who need services. Rather than focusing on duplication, I'd be focusing on, did two million people get the mental health service they need, and how?

Then, I think in terms of gaps, that's where the LHINs have been able to, through system planning and through their IHSP process, have a dialogue with their respective communities about what are the gaps in service. That's where the service registries, whether it's the mental health and addiction access to case management—we in Toronto now can tell you that there are 400 people waiting for case management, 42 people waiting for for ACT and 7,300 people waiting for supportive housing. I think if you had that capacity across the province, that would help you decide where you need to invest.

Mrs. Jane McKenna: So who's responsible, I guess my question is, for the two million people who haven't been seen?

Ms. Camille Quenneville: Could I just take a step back to your last question with respect to looking at gaps and inefficiencies? I think it's useful to note—and we talked earlier about a cabinet committee or a similar type of structure internal to government. By its very nature, when you put those cabinet ministers around a table, however many there may be, you are in essence bringing the machinery of government together, because all of those ministries have to get in line around the agenda of that cabinet committee.

It's not as though we can today tell you where the gaps and inefficiencies are, but I think as those ministries come together it will allow for a better dissemination of priorities to communities, funding to LHINs and overall direction of governments.

When we look at years four through 10 of the strategy, if it had an accompanying—as Steve pointed out, certainly the dollars that need to go with it, but also the internal structure within government that will drive that. Frankly, as we've all talked about today, it is more than the Ministry of Health. It's not simply a matter of saying the Minister of Health is responsible. It is across government.

Are there gaps and inefficiencies? I would argue that we operate on a shoestring and we do the best we can. We don't have enough money. But I think if we come together and collaborate, it would become very evident that there needs to be considerably more dollars to meet the need.

Mr. Steve Lurie: Just a final bit on the numbers: We've been very fortunate that the government com-

mitted $257 million to child and youth mental health, and before that, $220 million to adult mental health, but the reality is that $18.5 billion went into other areas of health care. The per capita investment in this province was $16.45 compared with New Zealand, which invested $198.

I would hope that if your committee is going to talk about gaps and wants to address mental health, you have to recognize that something as small as—we say we don't have money, but I think there's a deficit in mental health care. The select committee said there was a deficit in mental health care. An investment of $160 million a year in enhanced mental health services, which would solve some of the problems—not all of them—that we've talked about, would account for less than a third of 1% of current health spending. I think we have to be careful and not be penny-wise and dollar foolish. The assumption that there isn't money when we can demonstrate with our figures that lots of people in need aren't being served—and Mr. Colle's comment about the police being called, that's a symptom of an underfunded mental health system.

I would urge this committee to recommend that over time the government move to putting the right level of resources—that 9% of health spending that could be directed at mental health—and that the LHINs, through their mental health and addiction networks, can do what our LHIN has done very well. There are requests for proposals. They never have enough money to give us all we ask for, but I think if there's money on the table the system will step up.

Mrs. Jane McKenna: I totally agree with what you're saying in that sense, because I did my white paper on children and youth and it was amazing exactly what you're saying, that there are $257 million and each one of those people who came in to see me who were on the front lines said there were no performance-based outcomes and there were no evidence-based outcomes, and that the money they're getting is being used for the best resources and where it should go.

I think our biggest thing is that more money doesn't mean better, and I think we need to look at the resources of money that we have and know that there are evidence-based outcomes, that where it's going is what it says it's going for, and that it is giving the people who are getting the money—like children and youth—better outcomes of where that money goes. So I thank you for that.

Mr. Steve Lurie: I think on the adult side, we have a lot of evidence, both in Ontario and internationally. We know, for example, that case management and ACT can reduce hospital admissions by 50%. We know that supportive housing—as the mental health commission project showed, if you have access to the right kind of services and a rent supplement, you can stay housed.

So it seems to me the important thing is to fund based on the evidence, and there is evidence. And then, I know that we are able to provide the LHINs, and we have to as part of our accountability agreements, with evidence that we are meeting our service targets.

1700

There could be, over time, through the quality initiative that Camille talked about, a focus on some selected outcomes, but actually, I have to believe—and I've been working in this field almost 40 years—that we know more now than we ever knew about what works, and we're actually doing the kinds of things that work. The Housing First approach works; case management works; ACT works; early psychosis intervention works. We don't have to reinvent that wheel, and we don't have to over-research it. It's a question of recognizing that the kinds of things that the government has invested in that I just mentioned actually are effective interventions and they actually do lower costs in hospitals and improve people's lives in the community.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That concludes all the time, and we do thank you for taking your time to come here and talk to us this afternoon.

Ms. Camille Quenneville: Thank you, Mr. Chair, and thanks to all the members of the committee.

COMMITTEE BUSINESS

The Chair (Mr. Ernie Hardeman): While we're just concluding that part, I just wanted to point out to the committee that the information that was asked for about the employment has already been discussed. It has all been presented.

Interjections.

The Chair (Mr. Ernie Hardeman): And there is another report that goes with that chart that you have. So I want to say thank you, and we can all now study it, as we need some bedtime reading. Right? Very good. Thank you.

That concludes the hearings for today. Do we have any other business? Or do you want to go in camera to have more committee report writing? Yes, Ms. Gélinas.

M^me^ France Gélinas: I have no idea if I'm supposed to move my motion during open or closed—

The Chair (Mr. Ernie Hardeman): That motion would be in open session.

M^me^ France Gélinas: Do I do it now?

The Chair (Mr. Ernie Hardeman): This would be a good time, if you wanted to do it now.

M^me^ France Gélinas: Are you going to circulate them?

The Chair (Mr. Ernie Hardeman): It's being passed around. Ms. Gélinas is going to move a motion for the committee before we go in camera. In camera, we can't move any motions.

Interruption.

The Chair (Mr. Ernie Hardeman): We would ask those in the back who want to have a discussion if they would have it out in the hall.

M^me^ France Gélinas: You may have to repeat that louder.

Mr. Bas Balkissoon: Bang your gavel.

The Chair (Mr. Ernie Hardeman): Those who want to speak, speak in the hall, please. The committee would like to carry on with their business. We thank you all very much.

With that, Ms. Gélinas, you have the floor.

M^me^ France Gélinas: Well, this has nothing to do with the LHINs—and it does. I'll read it first.

I move that, pursuant to standing order 111(a), the Standing Committee on Social Policy study and report on all matters related to the mandate, management, organization and operation of Ontario's system of community care access centres (CCACs). The study shall include but not be limited to:

(a) Review compensation policies of CCAC executives and organizational policies in regards to compensation.

(b) Review of administrative practices including competitive bidding and procurement policies.

(c) Invite input from expert witnesses, including CCAC leadership and staff, health care service organizations that fall under the CCAC mandate, health policy experts, as well as patients and their families.

I so move.

The Chair (Mr. Ernie Hardeman): Ms. Gélinas has moved the motion. You've all heard the motion. Yes, Ms. McKenna?

M^me^ France Gélinas: Don't I get to make comments before we move on?

The Chair (Mr. Ernie Hardeman): I don't know. We haven't heard whether there's any objection to the motion.

M^me^ France Gélinas: Ah.

Mrs. Jane McKenna: Although we are not against a comprehensive review of the CCACs, we think the timing is inopportune. There is currently a motion before public accounts which will commit the Auditor General to conduct a thorough review of the CCACs, and the committee should wait until the report is made public.

The Chair (Mr. Ernie Hardeman): I'll call the member to order. That is debate on the motion, and the first debate on the motion goes to the mover of the motion.

M^me^ France Gélinas: All right. First, I wanted to state publicly that we will be supporting the call for the Auditor General to do a full review of CCACs. In 2010, in chapter 3, section 3.04, the Auditor General had reviewed home care services and given us a whole bunch of information about CCACs at the time. But having had the pleasure to be on public accounts—and if you read the Hansard, you will see that the Auditor General's docket is quite full. Last week, she was asked to look at—and it just escapes me—a study which she will take, and she made the point of saying that she does not think that she will be—

Ms. Cindy Forster: Winter road maintenance.

M^me^ France Gélinas: Oh, yes, winter road maintenance. How could I forget? Winter road maintenance, which she agreed to do, but she made it clear to the committee that her resources were stretched, and the soonest that she could do this would be in March 2015. Now, I have no problem adding that to her to-do list, but I know quite well that we are now looking late into 2015 before we would hear from her. But that doesn't mean that we shouldn't ask her.

In the meantime, the problems at CCACs have come to the surface. So many people felt that the only way to talk to the Legislative Assembly was to come and talk to us while we were doing the LHINs review. We were all there, or most of us were there. We went to nine different communities. In each and every one of those communities, people came and complained to us about CCACs, about home care services etc. Those people have spoken to us. We cannot ignore them. To me, we have a responsibility to show that we heard them and we will do something about this.

The nice thing about bringing it here is that—without sharing any secrets of the gods or anything—the diluted chemo drugs should be wrapping up soon. As soon as this has wrapped up, there should be time on the social policy committee to start, even if it's just to give people a means to be heard. It undermines our health care system to no end when there is a pent-up disappointment in our health care system and there is no way for people to be heard, no way of giving them hope that we will listen to them and we will make changes. This is what I'm asking to do. Certainly, there have been questions about the salaries of the people who work at the CCAC, which are enough to knock you off your chair, but there are more serious issues regarding quality of care for people who depend on CCAC services, home care services, and those people deserve to be heard. They tried to be heard through the LHINs review. It was not the place, but we should give them this outlet. It could happen quite quickly. It doesn't have to be long, but it needs to happen.

The Chair (Mr. Ernie Hardeman): Further debate? Ms. McKenna.

Mrs. Jane McKenna: I'll start again. Although we are not against a comprehensive review of the CCACs, we think the timing is inopportune. There is currently a motion before public accounts which will commit the Auditor General to conduct a thorough review of the CCACs, and the committee should wait until the report is made public. This report will be a valuable resource that will pave the way for a future review that is more effective and efficient. For example, the AG report will provide us with direction on what areas of the CCACs need the most focus and who the committee should call in as a witness. So to be clear, we are not against the idea of this committee reviewing the CCACs; we just feel that we can get more bang for our buck once the AG report has been brought to the attention of the public.

1710

For this reason, we propose the following amendment. I move that the following be added following "Invite input from expert witnesses, including CCAC leadership and staff, health care service organizations that fall under the CCAC mandate, health policy experts, as well as patients and their families":

That this review is subject to the passage of the motion that is currently before the Standing Committee on Public Accounts, that calls on the AG to conduct a review of the CCACs; and that the review should commence on the first regularly scheduled meeting day following the presentation of the Auditor General's report.

The Chair (Mr. Ernie Hardeman): Before we can put that amendment forward, we need a copy for all the committee members.

Mr. Mike Colle: Could we also have a copy of the motion before the other committee? It was mentioned by Ms. McKenna.

The Chair (Mr. Ernie Hardeman): I think in process, it is not an appropriate time to ask for other information as you're discussing the motion on the floor. This is an amendment.

Mr. Mike Colle: But she referred to that in the motion.

The Chair (Mr. Ernie Hardeman): No, no. Everything that's in this motion, you will have, but the other motion is not up for discussion at this committee. If you want to make that amendment as to the way it was printed, but it's not part of this debate.

We do have to start the next debate. The debate is now on the amendment, not on the original motion.

Yes, Ms. Jaczek?

Ms. Helena Jaczek: Yes, thank you, Chair. I'm leaning towards supporting Ms. McKenna's amendment. I honestly think that the AG is the best person to conduct this kind of assessment. That's really all I have to say. I think it makes sense to do it that way.

I'm going to be supporting Ms. McKenna's amendment.

The Chair (Mr. Ernie Hardeman): Okay. Before I can call the question, we have to have a copy for every committee member.

M^me^ France Gélinas: Just before the Clerk goes out, could the Clerk check, is it in order that in the motion of one committee, we dictate what another committee will do?

The Chair (Mr. Ernie Hardeman): No, and that's why, to make sure we clarify it on that, we get the copy of the motion because—

M^me^ France Gélinas: But the Clerk will decide that, not us. She is the one who gets paid the big bucks to decide if it's in order or not.

The Chair (Mr. Ernie Hardeman): Yes, it will, but we have to see the motion. The amendment can include a direction of doing something when something else has been done somewhere else, but it can't direct that someone else to do it. That's why it's important that we have a copy of the motion before we can actually call the question.

Mr. Mike Colle: I just have a question for clarification. Ms. McKenna is saying we shouldn't proceed with this motion because there's another motion before another committee, so if I'm going to decide this is better, that Ms. Gélinas's motion is better than the one before public accounts—I think we've got to see the other motion, to see if it includes some of these things that you have mentioned that are not included.

M^me^ France Gélinas: This is where I saw that we are ruled out of order because the motion at public accounts has not been presented to public accounts.

The Chair (Mr. Ernie Hardeman): There is no other motion at this time. Okay? The suggestion, through this amendment, is that there is a motion going forward, but we do not have a copy of that, nor does anyone else.

Mr. Mike Colle: It doesn't exist.

M^me^ France Gélinas: Well, it's in the process but, no, it doesn't exist.

Interjection.

M^me^ France Gélinas: But there's only a notice of motion. The motion itself, whatever people will be voting on after debates and everything—

Mr. Mike Colle: It's not there.

M^me^ France Gélinas: No, it will be there Wednesday afternoon.

The Chair (Mr. Ernie Hardeman): We don't know that. We'll wait until we get the copy of the amendment. If the amendment is strictly about using the issue with public accounts, it sets a time. If, in fact, public accounts never gets the motion, then this motion would never happen because the timing wouldn't be there, the trigger point would not be there.

Ms. Helena Jaczek: So, Chair, I guess I'm going to move in some fashion that we deal with this motion that we've just received next week.

The Chair (Mr. Ernie Hardeman): That's in order.

Mr. Mike Colle: Until we see what they really do, and that it's going to be before public accounts—

The Chair (Mr. Ernie Hardeman): Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you, Mr. Chair. I would tend to agree with my colleague on the basis that I think we're all after the same—

The Chair (Mr. Ernie Hardeman): Before you can make another motion, before that motion is in order, we have to see a copy of the one that we're waiting for.

Mr. Bas Balkissoon: But if I could just comment, the auditor has the folks within his organization who have the skills to do a much more thorough job than what this motion is saying. To me, if the committee does it, we can't do a similar job. Neither will we do justice to the process similar to the AG, and I've been involved in audits before, so I—

The Chair (Mr. Ernie Hardeman): Who will do the best job is not a topic for this motion either. It doesn't deal with that.

We will adjourn until we get a copy of the amendment.

The committee recessed from 1716 to 1721.

The Chair (Mr. Ernie Hardeman): We're back in session.

The amendment is out of order as the motion says that the review is subject to the passage of a motion that is currently before the Standing Committee on Public Accounts. I've been informed that there is no motion in

front of the public accounts committee to do that review, so that would make this out of order because it's referring to something that doesn't exist.

With that, we're back to the original motion.

Ms. Helena Jaczek: Mr. Chair, I'd like to move that—I guess it's an amendment to this—that this motion be considered next Monday.

The Chair (Mr. Ernie Hardeman): No, that's just a motion to defer it to the next meeting.

Ms. Helena Jaczek: Okay. Is that a motion to defer? Can I do that now?

The Chair (Mr. Ernie Hardeman): A motion to defer to the next meeting?

Ms. Helena Jaczek: Yes.

The Chair (Mr. Ernie Hardeman): You've heard a motion of deferral. All those in favour? The motion is deferred.

Mr. Mike Colle: Are we dismissed?

The Chair (Mr. Ernie Hardeman): No. Is there any other business for the open committee? If not, we'll go in camera, a closed meeting.

The committee continued in closed session at 1722.

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ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40e législature

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Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur l'intégration du système de santé local

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

Président : Ernie Hardeman
Greffière : Valerie Quioc Lim

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Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 17 March 2014

Lundi 17 mars 2014

The committee met at 1407 in committee room 1.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

ONTARIO ASSOCIATION OF COMMUNITY CARE ACCESS CENTRES

The Chair (Mr. Ernie Hardeman): I call the meeting of the Standing Committee on Social Policy to order. We're here to review the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act.

We're doing more public presentations, and the first presentation this afternoon is the Ontario Association of Community Care Access Centres. I believe they're here. As I read down the list: Sandra Coleman, chair and chief executive officer of the South West Community Care Access Centre; Barry Brownlow, treasurer and chair of the Hamilton Niagara Haldimand Brant Community Care Access Centre; Stacey Daub, chief executive officer, Toronto Central Community Care Access Centre; Frank Martino, medical doctor, Queen Square Family Health Team; and Laurel Stroz, care coordinator, Toronto Central Community Care Access Centre. I believe that's all the chairs we have at the end of the table, so we'll have to stop introducing people.

Thank you very much for taking the time to come and talk to us this afternoon. You will have a two-hour presentation. You will have half an hour in which to make your presentation, and then we'll have half an hour for each caucus for questions and comments on your presentation.

With that, thank you again for being here. The clock starts ticking now for your half-hour.

Ms. Sandra Coleman: Thank you very much, and thank you for the opportunity to be here today. As you've said, Mr. Chair, I'm Sandra Coleman. I'm here as CEO of the South West CCAC, but also in my capacity as chair of the board of the Ontario Association of Community Care Access Centres. I'm pleased to have the opportunity to speak with you again today and to introduce my colleagues. They will provide the core of our presentation today. Mr. Brownlow is the chair of the board of the Hamilton Niagara Haldimand Brant Community Care Access Centre and is also treasurer for the Ontario Association of CCACs; Stacey Daub, to my right, is CEO of the Toronto Central Community Care Access Centre; to my left, Dr. Frank Martino is a family physician at the Queen Square Family Health Team and past president of the Ontario College of Family Physicians; and Laurel Stroz is a care coordinator at the Toronto Central Community Care Access Centre.

LHINs are leading a significant transformation of health care at the regional level, and home and community care is a critical component of that transformation. In our presentation today, we'd like to address some of the questions that have arisen throughout the hearing process about home care and about community care access centres. We also have some recommendations about how local health systems could be improved to better meet the needs of patients today and in the years to come. They're appended at the end of our remarks and we're pleased to go through those in more detail, if you wish.

At this time, I'd like to turn it over to Mr. Brownlow.

Mr. Barry Brownlow: Thank you, Sandra. As board members, we are responsible for ensuring that the organizations we govern deliver the highest quality of care possible to our patients while making the best possible use of taxpayers' dollars entrusted to them.

I'm an accountant by profession, and I look for economic benefits. A recent comparison showed that home care costs average about $48 a day, compared to over $800 a day in a hospital and $126 a day in a long-term-care home. Now, I'm not suggesting that all the care that happens in hospitals or long-term care can happen in-home, but given changes in technology, medical innovation and patient choice, more care is taking place at home than ever before, and there are social and economic benefits to doing so. These benefits, along with other factors, will continue to drive growth in this sector.

As boards, we are responsible for hiring and retaining CEOs to provide effective leadership for our organizations. We have 14 CEOs managing $2.2 billion of investment in home and community care, and we hold them accountable for managing the efficient and effective use of these resources.

There has been public debate about the compensation of our CEOs, and I'd like to provide some historical context. In 2006, 42 relatively small community care access centres were amalgamated into 14 larger organizations. The new organizations were more complex, they covered more geography and they served more patients. In 2009, boards undertook a third-party, evidence-based market review for CEO compensation. Based on this

review, which considered the substantial growth in budget, scope and complexity of operations, boards made decisions regarding adjustments. In 2010, our executive compensation was frozen as part of the broader public sector compensation freeze, and remained frozen until 2012. At that time, no further freeze was requested, nor required of us by the province.

As board chair, I take very seriously my responsibilities for ensuring that we have strong leadership in the CEO position. I'll illustrate with a personal example: In Hamilton Niagara Haldimand Brant—which has a population greater than Canada's fifth-largest province, Manitoba—we employ care coordinators who work with patients, their families and our system partners. Last year, they supported 75,000 patients with care plans and received more than 4.7 million patient visits.

To be able to recruit and retain capable, competent leaders who can oversee a complex service delivery organization in the health sector, we must be able to offer appropriate compensation. We understand that the province is considering additional measures on executive compensation; we welcome that, and hope that it will spur a larger debate on a broader human resources strategy for home and community care.

Thank you very much for your time, and I'll be happy to answer your questions. I'll now turn it over to Stacey Daub.

Ms. Stacey Daub: Thank you for the opportunity to be here today. I'm pleased to provide some perspectives on home care as you review the Local Health System Integration Act.

As you know, home care is garnering a lot of attention. This heightened interest is not surprising; it reflects its growing importance to Ontario. But home care itself is not new. Publicly funded home care has been around in Ontario for 50 years, but it's new to many more people. More people are aging and wanting to live fully, and as independently as possible, in their communities. More acute-care patients are getting treatments and recovering at home, rather than in hospital, and people with multiple complex health conditions, who just five years ago would have lived in an institution, are now living in the community. And many more individuals are choosing to live their final days, and die, at home.

All our patients have families, friends and neighbours who love them and who look out for them, so there is a rapidly expanding circle of Ontarians impacted by home care. It is becoming a major component of the health care system. When you consider the impact on families, millions are impacted, so we know there are strong opinions at times about our work. We understand the heightened scrutiny and accountability that comes with delivering a service that touches so many lives.

The CCACs are eager to participate in a public policy discussion aimed at improving services to patients. With home care set to take on an even more prominent role in the delivery of universal care, the province needs to examine what is working well in our home care system and to determine what we'd like to see more of in the future. We need to focus on understanding and solving the right problems. So I'm pleased to offer some thoughts and ideas about some of the most important questions we need to think about to strengthen our home care system, informed by our experience as care providers and inspired by the needs and the hopes of our patients and their families.

Based on my experience, I'm going to talk a little bit about how we came to have the home care system we do today. Then I'd like to propose four questions we should be asking about the future of home care.

Three successive governments have shaped the way home and community care is structured, organized and operating in Ontario today. The CCACs did not choose their structures, their roles, or their operating model. I think it would be fair to say that if Ontarians were sitting down today to design a system of home care, they would likely not choose the exact model we have right now. That said, there are many strengths in the way home care is being delivered.

Because of CCACs, there is a single point of access and accountability for home care in every community across Ontario. We have care systems in place that enable over 650,000 people a year, of all ages, to be supported at home and in their communities. Each month, we help over 16,000 people go from hospital to home and receive home care, generally within one day of leaving hospital.

We serve the highest-acuity home care patients in the world. In fact, CCACs contribute to Ontario having fewer hospital beds and shorter stays in hospital compared to all other provinces.

In Ontario, there is one electronic health record for every home care patient. We have a single IT network. We are the only part of the health system to have this.

One of the reasons I believe there is an abundance of opinion on what CCACs should be doing is because we are the point where all the parts of the system meet. We oversee the quality of care at the patient level. When we hear a complaint or a concern from a patient, it's our job to follow up and address it.

We are present for some of the most difficult decisions that people ever have to make. We sit with seniors and families and explain what the public system can provide, and know that many families worry that it won't be enough. Sometimes families feel that it is time for their mother to move into long-term care. We are the ones to explain that her needs are not as great as those of many other seniors, and so she will need to wait.

We do our best to provide support and a caring touch as we watch caregivers deal with the anger and helplessness that comes with watching a loved one die.

We sit in meetings in hospitals and defend the decision not to place a patient in long-term care because the patient is capable of making that decision and does not want to go.

We need to make tough decisions about care levels that nurses or other providers disagree with, because we are the stewards of public resources that, like all public

spending, have limits. Our job is to distribute these resources equitably. We focus on the needs and the wishes of the patients, not the providers, with a focus on those most in need. Wherever demand exceeds supply, we ensure a fair and equitable access to long-term care, adult day programs, and other services.

These roles are not easy. We should be held accountable for carrying out these roles fairly and compassionately, but these are necessary roles that government has directed us to do.

Thousands of dedicated, knowledgeable, compassionate, creative and committed people are choosing home care as their place to make a difference to patients and to the province. Shortcomings in the system should not be attributed to the integrity of the people working in home care. Today, we invited Laurel, one of our care coordinators, to talk about her work. We thought this committee would benefit from hearing first-hand about the challenges that care coordinators overcome to help their patients. We need Ontario to begin thinking and talking about strengthening the home care system to make the most of the skilled and committed people who work throughout the sector. So let me pose the four questions that I believe we need to address in thinking about the future of home care.

First, how do we organize home care to deliver the best care at the best value?

Currently, there is one organization accountable for home care, with many organizations involved in its delivery. The CCACs employ care coordinators and some other health care professionals, like nurse practitioners and pharmacists. However, much of the care for our patients is delivered by people who are not our employees. We have contracts with 160 agencies to deliver nursing, therapies and personal support services. We estimate there are some 24,000 people delivering home care in Ontario. Some of these staff work for non-profit providers; some work for for-profit providers. These contracts and the contracting process, which has had many changes over time, have been controversial.

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On top of this, many patients receiving our care also receive services from other community organizations—services like home support, Meals on Wheels and transportation. Our patients also receive care from multiple parts of the health care system. Most of them have family doctors. Many get services and supports from acute-care, specialty hospitals and, increasingly, from non-traditional service providers.

Our patients tell us that the health system is "overwhelming" and "confusing" and that they "don't understand." They tell us they want better communication and more information. We see our role as integrating all of this care and finding ways to make it work for our patients.

There are likely better ways of organizing the system so that it is easier for patients and providers, but there are no straightforward, silver-bullet solutions. Several options have been suggested, like merging LHINs and CCACs, or devolving CCACs into 11,000 primary care practices. There's no evidence to suggest that these options will improve patient care. In fact, CCACs have been restructured many times. Most recently, we merged into 14 CCACs to align with LHIN boundaries, and I think that change was a good idea.

As a health care leader, I know how to lead mergers. I also know that they are painstaking, time-consuming, energy draining and can be costly. But the truth is, as public policy challenges go, it's not that hard. It doesn't take that much creativity or innovation. What is harder work, but offers far more value for patients and Ontarians, is addressing the unique needs of patients and working with our partners to deliver better home care. So I'm skeptical that one more merger is the right option, particularly when so much is already happening to improve integration of care across organizations.

Health system leaders, experts and policy-makers should be consulting with patients, working to answer the questions of how best to organize the system and the delivery of care around the needs of patients.

The second question I'd like to pose is: How do we ensure a strong and stable home care workforce? Let me share a little bit about the people who work in home care. They are a very special lot. They've chosen to work in one of the most unpredictable, uncontrollable environments: a person's home.

One of the reasons home care costs less is that wages paid to many home care workers are often lower than the wages paid to workers in other parts of the health care system. This is especially true of personal support workers. They are deeply valued by patients. They spend the most time with our patients, and they are essential to keeping people at home. We should be asking ourselves if their pay reflects the importance of their work and what we ask of them.

As you know, CCACs have no direct control over salaries or administration within the organizations that we contract with. Many of us have found creative ways to improve the working conditions of personal support workers. We have organized team-based care and given personal support workers a stronger voice in how care is delivered. But the real needs and concerns of personal support workers warrant a fuller discussion of their own. In fact, if we are going to increasingly rely on home care, the province should have a broader discussion on a health human resources strategy for the sector. We need to consider how we support the paid and unpaid caregivers that the system so heavily relies on. We need to examine how the health system can improve compensation and support for those who do some of the toughest jobs in health care.

Third, how do we ensure a funding strategy that provides equitable access to care? The current government has made unprecedented investments in home and community care, but there is more to do to ensure equitable funding and access to home care across Ontario.

Our funding is a reflection of historical funding patterns and more recent decisions of individual LHINs.

The result of that funding is uneven across Ontario. This impacts access and service levels.

Another factor to consider is that the demand for home care is growing dramatically. We are supporting patients whose needs are greater and who need care for much longer. Many long-term care homes, CCACs and community services have wait-lists. We need a long-term funding and capacity planning strategy that builds the capacity to provide appropriate care in every community in Ontario.

I know that attempts are being made to address this question through new funding models, but these may not be sufficient to address the pressures that the health care system will feel in the coming years.

The fourth and final question is: How can Ontario's home care system increase transparency and choice for the citizens we serve? People want to know how to plan for their care needs. Families want to know what supports are available to their loved ones. In our current system, it is not always clear what services and supports people can expect. We can do a better job of this.

Places like Australia and Germany have standardized care packages. This allows people to know exactly what the publicly funded system is and is not able to provide. Other countries provide a dollar amount that lets patients and families choose the services that are right for them. Ontario's policies could allow clients more flexibility and choice about home care.

These are only four broad questions to start us thinking about the future of home care. As I said at the beginning of my remarks, the home care sector is gaining profile. But it needs to garner much more thoughtful public attention. There are no simple solutions, no easy paths. The debate will be difficult, with lots of opinions. I believe it is important that we use as much evidence as possible, and the most compelling evidence will come from the experience of home care patients themselves. But if we do decide to make changes to the system, we should take great care not to destabilize the home care sector. This isn't something that our patients or the health care system can afford.

You know, I began my career as a personal support worker. I've worked in a service provider agency, and today I lead a CCAC. My perspectives on home care have changed over time, but I do know that all of us who work in the CCACs believe that Ontarians deserve the best home care system that we can offer them. We know you share that goal, as do your fellow MPPs. So let's start having that discussion. I look forward to your questions, but first, I will turn it over to Dr. Martino.

Dr. Frank Martino: Good afternoon, and thank you for allowing me to contribute with my remarks. I am Dr. Frank Martino, a family physician at Queen Square Family Health Team in Brampton and past president of the Ontario College of Family Physicians. I'm pleased to be here today to offer my perspective.

A few years ago, primary care and home care worked very differently. Today, I'm grateful and pleased to report the picture has changed and, I must say, for the better. As a primary care practitioner who works in my community daily, I can speak from experience to the positive and integral nature of the partnership between community care access centres and primary care and to the way we manage patients in the community together, especially our complex seniors with multiple conditions and patients that have been recently discharged from hospital who require services at home.

I'm pleased to say that I have a CCAC care coordinator who is dedicated to and works directly with my team. The system is working much better for me and my patients now, because she helps connect the dots for us. Sandra Hastings is crucial in helping me get to know what my patients' needs are and linking them to the entire basket of services available to them. Together we support patients on their journey through the health care system. I hope to reflect with you, if requested, on patient stories that I have experienced personally and that have been told to me by my colleagues that speak to this collaboration.

As the people who live in our community grow older, and more and more people are living at home longer with complex, long-term health needs, the role of care coordination at the patient level becomes fundamental to the care we provide. We also need to work together, and the partnership between community care access centres and primary care is crucial to the quality and success of the care delivered in the community. CCACs are an important collaborating partner for primary care, and as we move more towards team-based care, community care access centres offer an existing, organized team that can provide physicians and our patients with a multitude of services. Evidence tells us that team-based care is better for patients, improving their health and wellness significantly. Working together, we also reduce emergency department visits and offset costs in other parts of the health care system, preventing readmissions and reducing hospital length of stay.

When I assumed the role of primary care lead in the Central West LHIN, what my family physicians asked from me was to bring dedicated care coordinators into their practices and for them to better understand the available community-based services that they could access. More and more, there are dedicated CCAC care coordinators that are affiliated with groups of family doctors to create an efficient process where doctors are aware of the basket of services available to patients in their homes and communities through community care access centres. This way, doctors have that one-to-one contact with the dedicated care coordinator who can tell them how their patients are actually doing at home.

In the Central West LHIN, we are pleased to have a dedicated physician access telephone line for effective and efficient interaction. You know, family doctors are often a person's first and most common point of contact with the health care system. With community care access centres, we're developing virtual teams. In my LHIN, this leadership is crucial to providing coordinated care and seamless navigation for patients. Together, we can

make those very important connections. We piece together not only the big picture of the person's life and what they need, but also the whole picture. This virtual team approach adds up to quality care for the patient.

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Care coordinators act as our eyes and ears in the home environment. They help us keep people safely at home, remain independent in the midst of their loved ones for as long as possible and out of hospital and long-term-care homes. I would be concerned about the system making changes in a way that would disrupt my access and my patients' access to a centralized system for home care.

When we all work together, we make a meaningful difference because patients receive better care at home and across the entire health care system. Community care access centres facilitate this at the patient level in homes and in communities. We need to build on these successes. I am excited about the possibility and prospects that exist in this continued collaboration and partnership.

Thank you for your time, and I would be pleased to answer any questions you have of me later.

Ms. Laurel Stroz: Thank you for the opportunity to be here today. My name is Laurel Stroz, and I'm a care coordinator at Toronto Central CCAC. I work on a diverse, inter-professional team, consisting of nurses, occupational therapists, physiotherapists, social workers and speech pathologists. I am a social worker by profession.

Over the past several months, I've been disheartened at times to hear my work described as administration, bureaucracy and paper-pushing. That's why I wanted to be here today, because I assume that the individuals who make such comments have never had the opportunity to discuss care coordination with myself or with one of my colleagues.

We are health care professionals who play a critical role in the home and community care sector and in the lives of the people that we care for. My toughest days are the ones where I visit seniors who are isolated, unwilling to trust and refusing services. I've visited homes with unimaginable living conditions. I've stood in the midst of squalor, moving from foot to foot to avoid having cockroaches crawling up my leg and then seeing those cockroaches climb onto my client's wheelchair and person; with bedbugs hopping around the furniture; with mouse and dog feces spread across the floor. I've looked in cupboards that are devoid of sustenance.

Oftentimes, these are not the seniors who embrace your assistance. These are individuals who are fiercely independent, wanting to live in their homes for as long as possible, but afraid to ask for or accept help. As a care coordinator, you begin by looking for a way into their lives. You need to build trust before you can provide any sort of assistance. Then, you set about to create a circle of support.

Care coordination is not an easy job, but it helps provide a face to the health care system that many very sick individuals struggle with. We help individuals navigate that system and walk with our clients through their health care journey.

Ms. Sandra Coleman: That concludes our formal remarks—

Interjection.

Ms. Sandra Coleman: Oh, sorry. Go on. Go ahead. Sorry.

Ms. Laurel Stroz: While it is not always easy, it is a job that I love because it makes a difference to people. We sit at the bedside of palliative clients. We ensure that their final wish to die at home is respected. We ensure pain is managed and that the family is supported. We help kids who no one else thinks can go to school attend school with the other children from their neighbourhood. We do this all with the support of a care team, one that includes nurses, personal support workers, doctors, pharmacists and other community services. Sometimes I have to push harder to make sure things happen the way they need to. Sometimes the team has different ideas; we challenge each other. My job as a care coordinator is to mediate that discussion, to help the team rally together to meet the client's needs.

The best model is one of collaboration from acute-care settings to primary care to home care. By working together, we increase the capacity for seniors to stay at home, to successfully have their health care managed outside of acute-care settings, and to ensure that clients have what they need when they need it by acting as a voice and advocate for those who need our assistance most.

Care coordinators care for our clients. We have searched streets, parks and homeless shelters for an elderly person with dementia who is unsafe, who has health complications, such as hypoglycemia. We sort through boxes of medications in clients' homes, removing expired products and reducing the risk of overdose. We sit through hospital discharge planning meetings and we hear a list of reasons why an older person shouldn't go home, but then listen for when the client wants to be home, and then we help make it possible.

Like my colleagues, I am a CCAC care coordinator. It's a job that we're proud to do. Thank you very much for having me here today.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. Now you can make your closing comment.

Ms. Sandra Coleman: Yes. I apologize for intruding. That concludes our formal remarks. I appreciate that we haven't talked a lot about LHSIA, but as I said, you've heard from us about LHSIA in some of the individual sessions leading up to today. There is a consolidated set of recommendations that are appended to our remarks, but we wanted to take our time to address some of the things that you're hearing about: community care access centres. You have our written summary. We'll leave that with you. We're pleased to answer all your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much. Thank you all for your presentation. That is almost exactly to the end of the 30 minutes, so we will now have 30 minutes for questioning from each party.

We will begin with the official opposition. You don't have to use all your 30 minutes at once. We'll just make

the rotation and keep going until everyone's time has been consumed.

With that, Mrs. Elliott.

Mrs. Christine Elliott: Thank you very much for coming this afternoon to make your presentation. I was just following you along in your presentation. I noticed on page 6 you were talking about shortcomings in the system and that they should not be attributed to the integrity or values of the people working in home care. I'm not sure who should answer this, perhaps Ms. Coleman. What do you see as the shortcomings of the system presently?

Ms. Sandra Coleman: Stacey and I can both address that. It was in Stacey's comments as well. We know from our patients' perspectives that we've made great strides; for example, with programs like Home First that have been now rolled out across the province, across all CCACs working with our hospital, LHIN and other community partners. With that, hundreds of people in each of our communities are able to be at home instead of hospital or long-term care. They have better health outcomes and it saves money for the health care system as well.

But that care is still available to fewer than potentially could benefit from that type of enhanced service level in the community. There are questions around improvements in terms of the service levels that we can provide, as well as, how do we continue, for example, on the collaborative partnership that Dr. Martino spoke to, and ensure that there is a dedicated care coordinator with every primary care physician across the province so that that type of teamwork is spread and replicated.

The CCACs have made a commitment to having a dedicated quick-care coordinator attached to every primary care practice. We're partway there now but we need to continue that journey. Stacey?

Ms. Stacey Daub: The only thing I will add—I mean, I think I made most of the commentary in my remarks. I think that the home care system, like other systems we have—the acute-care system, the long-term care system—were designed for a time and we have some catching up to do in terms of getting them ready for the next generation of patients and clients.

I think Ontario in some ways is not unique in that there's growing demand for home care. I think the public policy challenges that we face in terms of the levels of support we can provide at home, how we can become much more coordinated, as I talked about, how we can build a stronger health human resource force, how we can make sure that there's fair and equitable access and funding across the province so that every Ontarian has the opportunity to remain in their community—I think that remains a challenge. I don't think it's for lack of trying, whether it's at the individual level—but many of these issues, I think, are quite complex and need what I believe is a very thoughtful debate to try and understand from the patients' perspective, what are the most important things we can improve?

When I make reference to shortcomings, the difficulty we have in some circumstances where people need services, whether it's long-term care, or other really good examples, I think, are young adults who have very complex medical conditions and parents who would like to see other community environments for them to live in—those are the types of shortcomings I'm talking about, which I think every system has. But I think the job that Laurel has is very difficult, not only because you're trying to navigate a complex environment, but there are also just some services that aren't available and you have to be creative and find other ways to actually do that.

Mrs. Christine Elliott: Would it be fair to say it's primarily a funding-related issue that's the shortcoming? Or are there other structural problems that you're encountering that impede your ability to deliver the best possible coordinated care?

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Ms. Stacey Daub: I could only speak in Toronto, where I feel, from a funding perspective locally, I have had a lot of support, both from my local LHIN but also from my hospital partners and others who are quite interested in investing in home care. Locally, I would say that it is a whole new generation of clients that we're serving. In the past, if we had a simple client who was coming home to get some post-hospital care, you didn't need the level of integration that you need today. Today, we need to spend more time building a team in the eyes of the client and it's harder work. I don't believe that we could ever employ everybody who interacts with that client, so you have to figure out a way to develop a relationship with primary care. It's not as easy as popping a care coordinator into someone's office. It's about relationship-building. It's about shared purpose and figuring out ways to do things together when physicians might have done them very independently and we might have done them independently. You have to learn to work differently with other people.

Mrs. Christine Elliott: Other than increasing funding, what do you think would be the most important thing that the government could do to strengthen the role that you play?

Ms. Stacey Daub: I came here today not with prescriptions, but with some ideas. I think the issue, from my perspective, is that I could tell you what I think, Ms. Elliott, but my fear would be that I would be speaking from my perspective, from the perspective of my organization. I think the true strength in understanding how to strengthen the system would come from engaging patients and the people who receive service to understand what's most important to them. I can tell you what they've said to me, I can tell you what personal support workers have said to me, but I think, in some ways, we would be better off to hear it from them.

I did mention in my address the issue of control and choice. I think that we have a different generation of home care consumers who want more control and choice over their services, and I do think that we have some policies in place that make that difficult. I think that that wouldn't be a difficult thing to do to start to figure out how, even if you spent the same amount of money—and

I'll give you a quick example. We serve a lot of children with medical complexity. These are kids who may have had a tragic accident or were born with a particular type of neuro-developmental issue, and at the very beginning of their lives, parents want a lot of support and they want a lot of people coming in because they're learning how to care for their child. But very quickly, they become the expert in their child's care and they want more choice over the people who are coming into their homes, the types of individuals, the types of services that would be unique and helpful for their families. Our system, I think, is still based on a different time when there was maybe less complexity in the clients that we served, as well as people not wanting as much control and choice. People want more control and choice now. I would like to be able to do that with families.

We've done some small tests where we've taken families and we've looked at how much we've spent with them on their care, and we've said to them, "If you were to design this differently and if it was really going to help you to do the best in caring for your child and your other kids, what would that look like?" We've been able to work with the rules and bend the rules a little bit to be able to design services that make a lot more sense for them, but aren't really in keeping, I think, with what the policies would kind of dictate.

Mrs. Christine Elliott: So a broader sort of consultation with the public would be something that you would think would be in order? I can certainly tell you that that's what I hear in my community office as well from people who are getting some level of home care services, but that might not be what they want or need. They'll tell me, "They're offering me X hours of a certain service, but what I really need is in another area." So a greater degree of flexibility, I think, would certainly be in order.

You also mentioned, on page 5 of your presentation, that there is one electronic health record for every home care patient.

Ms. Stacey Daub: Yes.

Mrs. Christine Elliott: That's certainly at odds with what I hear from some of the home care service providers in my area, who tell me that it's still very reliant on phone calls and faxes. So I was wondering if you could elaborate on what you mean by that, please.

Ms. Stacey Daub: Sure. Prior to the merger—and anybody can jump in—of the 14 CCACs, we had, I don't know, six, seven, eight different home care systems, and every one of those home care systems would have interacted with the providers, our partners in care, in a different way. We have had CHRIS, which is one record—we have one way to communicate with our providers. We have something called health gateway—

Ms. Sandra Coleman: Health Partner Gateway.

Ms. Stacey Daub: Sorry, Health Partner Gateway—and it provides a common way for us to communicate with our providers. I think you're probably referencing the fact that some of our provider agencies have records as well, but I would say, from my perspective, that they are much more integrated—light years ahead of what they used to be—and there are many of us who are trying to work through the issues of reporting and thinking about how to do that differently.

For example, with our palliative team that works in my community, instead of the phone calls and faxes, they have a daily virtual huddle. The physician is on the line, the nurse is on the line, and the care coordinator. They do quick bullet rounds of every patient that they serve in our community. They talk about what's most important to that client and what they're working on, and it eliminates all of that paperwork.

We need to do more of that in every part of the province, and there are all kinds of reasons why agencies and others—you know, privacy has been a blessing and a curse, I think, in some ways, in the province, but we need to work through those. If you ask most of our patients, they would say that they would rather share information in a safe way amongst us than be overly careful about it so that we don't know what one another is doing. I think there's more work to do, but I think we've made enormous progress from the past.

Mrs. Christine Elliott: Okay. Thank you. I have a few more, but I'll wait till the next round.

Mrs. Jane McKenna: Thank you so much for being here today. I guess, first of all, you would measure your success at the CCAC by the patients and how they're feeling in the system. I can say for myself, as an MPP, that we're grateful for the caregivers, because they're exhausted. Without them picking up where they're totally struggling, because they don't seem to be getting the answers that they need—the frustration when they come into my office, as an MPP, is heartbreaking for us. I know for myself trying to get through the system, it's fragmented as it is, and I don't know how the average person would even be able to facilitate that.

Being here today, when we've been going through all of the processes of all this, I guess my one question to you is: We're trying to find recommendations to make it better, because it is for the patient, right? It's not about anything else except getting them the proper necessities that they need and deserve. So what would you say that we could do for ourselves, as MPPs, to be able to facilitate that information for the people that are coming in that are struggling?

Ms. Stacey Daub: One of my MPPs is here. Mike Colle may not recognize me, but I work closely with Michael Prue, and I just met Doug Holyday.

It's interesting, I don't get a lot of complaints through my MPP office. I get more of those who are trying to figure out a way to connect to people who are confused by the system. So from my perspective, I do think that the care coordinators' roles are really important in terms of connecting the dots.

It's not for all populations. As I mentioned before—I'm saying this is simple, but it's probably not simple for the people who have received it—you can take a knee replacement. They need simple coordination between the hospital and the rehab provider, but they don't need that level of coordination. Once you get to much more com-

plex situations, I think care coordinators would be very useful.

The other thing that I think we do as a system is that we have a tendency to focus on the client and the individual, not the caregiver. For example, we may have a daughter who really wants her mom to move to long-term care, into a nursing home. She lives an hour away from her mom. She's very worried about her. She thinks she's unsafe. She thinks she's going to fall down the stairs. The client themselves, the senior, does not want to move into long-term care. It is our role to support a client if they're capable of making that decision, and we support them to stay at home. What I think we haven't always done a good job at is then turning to the caregiver to say, "Okay, we're going to support the client. Now, how are we going to support the daughter, so that the daughter feels that she's supported as that caregiver?"

I know you're going to hear from Samir later. He did a big consultation with caregivers, and they talked a lot about what they need more of from the system. We have to spend a lot more time thinking about the caregivers. They're carrying an increasing burden. And I think back to my other point: I think that if we could give them more certainty about what they will get from the public system—it's not that transparent. It's not that we're trying to hide anything; it's just not that transparent in the way that it's—it's not something so easy to understand. There are countries that have had service packages and service levels that are much more transparent, so you can at least have more control to think, "At least I know about the public system; now I can think about what we need to do," whether it's a family, a neighbour or others.

Those are a couple of examples. I don't know if anybody else has any suggestions.

Ms. Sandra Coleman: May I add?

Mrs. Jane McKenna: Yes.

Ms. Sandra Coleman: I might turn to page 24, where we start our recommendations. I think that the first two are on-topic for your question, Ms. McKenna. One of the reasons for the frustration, absolutely—oh, I'll wait and make sure you have that in front of you.

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Mrs. Jane McKenna: We don't have 24.

Ms. Helena Jaczek: We stop at page 16 of your recommendations.

Ms. Sandra Coleman: Okay. Do you have a section at the end that says "Review" and then lists several recommendations?

Mrs. Jane McKenna: Yes, we do.

Ms. Sandra Coleman: Okay. So I had the wrong—

Mrs. Jane McKenna: Yes, 16.

Ms. Sandra Coleman: We have a different page reference, but at least we're on the same page, so to speak. Everybody's there?

Interjection.

Ms. Sandra Coleman: In addition to absolutely what Stacey said, I think one of the other reasons for the complexities is also because the services are different from community to community, and I don't just mean from Toronto Central compared to South West. Even within South West, the services available in Oxford county can be different than those available in London-Middlesex compared to the Owen Sound area, for example, within our community.

There would be a tremendous impact from having a pan-Ontario, cross-system capacity plan that would take stock of how many community services, how many assisted living and supportive housing locations, and, yes, how many long-term-care beds and hospital beds, but the government and all of us have a pretty good handle on that. But it's in some of these other services that are absolutely critical to people, especially as we are shifting more care to community: assisted-living spots, adult day living places, mental health supports etc. Right now, there is no single place to go to understand what that capacity is, how variable it is and, therefore, how to support investments to make a difference.

In the LHIN areas where they have started to make some of those changes and do an assessment of the variability and capacity within their geographies—for example, in South West, they discovered that there was a four- or fivefold difference in the number of assisted-living places compared to where you were within the South West. That's just within the South West, never mind comparing to the north and other places in the province. That analysis is then guided—their investment strategy of how to, in turn, ensure that they're attempting to have more equitable access to some of those important services.

I think this fits with your question as well, that there is not an equitable distribution of capacity and services in the province, and I think the LHINs are in an ideal position to be able to undertake that kind of analysis.

Mrs. Jane McKenna: I guess my question is, whose job description is it, then, to be the single place to figure that out for everybody?

Ms. Sandra Coleman: Well, I think it's the LHINs' job to lead, but they would be working, then, with all of the health service providers to understand their part in that, and the CCACs would certainly have a tremendous amount of data to feed into that. Because of where we sit, looking at patient flow across the system from hospital to home to long-term care, being a single point of access to adult day programs, assisted living etc., we can be a single source of information that would be very important to that, but there would be other pieces that you would need to understand as well—so how to collate that in a way that isn't just informative within South West but actually can inform a pan-Ontario strategy to ensure more equitable access.

Mrs. Jane McKenna: So is that in the works to do that right now?

Ms. Sandra Coleman: Well, as I said, some of the LHINs are going forward with exactly that type of capacity planning. We think there would be real benefit to tackling that across all of Ontario.

Dr. Frank Martino: If I could just speak to that for a second, In the Central West and Mississauga Halton

LHINs—the two LHINs have actually gotten together and looked at capacity when it comes to senior services, and at the table is primary care, community care access centres, hospitals, long-term-care organizations and community providers.

It is really important to understand that there is some fat in the system. We're just not accessing it appropriately, and probably not having significant flow-through through those services.

Mrs. Jane McKenna: I have one more question. I think the number one thing that people fear is the unknown, right? When they don't have the information at hand, it's fearful for them as a caregiver, or whether it's the patient. I think it's great to have home care, but where I struggle with is that we're doing it because we don't have any long-term care and we don't have anywhere to put these people, so we kind of say, "Okay, here, we're going to put you in home care." And because it's so complex and there are so many variables that you're saying here today of trying to match everybody up with everything, how can we figure out, if we're going to do home care to the best of our ability for the people who deserve to be at home, how do we streamline for those people to have the best care that they can have at their fingertips? Because not everybody's the same, right? What you offer somebody, like what Ms. Elliott was saying—just because you offer that, they don't need that. How are we going to figure that out as MPPs—to give them these services so they're not coming in feeling frustrated and exhausted—that we're trying to figure out something for them? How do we streamline that for them if we're going to do home care?

Ms. Stacey Daub: I think I mentioned earlier that I do think more information about what the public system can provide and having a better sense of what that actually looks like, and including that in people's planning and making that very transparent and open to people, would be very useful.

It's a moving way to think about the system, because if we would have thought about what home care looked like even five years ago, we would have been constrained, I think, by not seeing the possibilities of what could be for many people. So we have to be very careful that we think about the future not in the rear-view mirror. I think the first thing is to think about: What are the types of people and individuals and how much care do we think is possible to be provided at home, at what level, and when should someone actually be considering long-term care, and having a better understanding of that?

If I think of five years ago, before Home First, I always tell the story that when people were very uptight about the ALC issue in the province, I got a call from my LHIN to say, "You need to help us to fix this." We went into the hospitals at the time—maybe it was longer than five years ago—and we did what we thought was the right thing, which was to speed up the process: "If only we could get the long-term-care homes to respond quicker." What we ended up doing many, many years ago was having more people go to long-term care than needed to. Once they got to long-term care, they got their medications and they recovered from whatever illness they were in the hospital for. We saw that there were many possibilities to get people home. So we have to be very careful to think about the future and what capacity.

Right now, I think the one big gap is between home care and long-term care. Many of us are trying to think of that whole idea of one-on-one visiting in a client's home. When you talk, for some people it becomes overwhelming. You need a lot of support. What you might hear from some of your constituents is that they have different people coming in. If you have someone who's getting care seven days a week, you can't have the same person coming in every day of the week.

There are other models. In Toronto, we've developed something called neighbourhood care teams. We have teams of personal support workers in buildings who fan out to a neighbourhood. In Mississauga Halton, they have Supports for Daily Living; other places have assisted living. At some point, when the care needs become very significant, I think you need to think of—there's a gap. People don't want to go to long-term care, but the intensity of the service that they need—we need to think about redesigning that a little bit or it does become overwhelming for people.

Mrs. Jane McKenna: That's it for me. Thanks.

The Chair (Mr. Ernie Hardeman): Okay. The third party: Ms. Gélinas.

M^me^ France Gélinas: Welcome to Queen's Park, everyone. I'll go in a little bit of a different direction. I realize that CCACs are able to offer good jobs to the people who work for you. The jobs have respectful pay; they have benefits; you offer a pension plan. This is the type of job that every health care worker should have access to. You also negotiate contracts with care providers, but then the people who work for those contractors—mainly PSWs—certainly do not enjoy respectful wages or benefits or pension plans, like the people who work for CCACs.

I know that you value good jobs, because you offer them to your own employees. Where is the disconnect? When you do negotiate with the care providers, how do you take this into the mix? Because the example you were just giving us, that you don't have the same providers—well, I would tell you that if more PSWs had full-time jobs, the number of people that came to give you your bath would decrease exponentially and you would see the same person coming in over and over a whole lot more if you have full-time jobs, respectful wages, meaningful benefits and pension plans, none of which exists. When you negotiate those contracts, how do you take that into account?

Ms. Stacey Daub: Maybe I'll start, and then I'm going to pass it over to Sandra about the negotiations and the contracts. Unfortunately, you weren't here at the very beginning; we did talk about personal support workers. I, myself, started as a personal support worker; my mother was a personal support worker for Red Cross. So I'm

very familiar with personal support workers, and have relationships with many.

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What they will tell me, number one, of all the things that are most important to them—because lots of people speak for them, and I would love to have them here today as well to speak for themselves—is guaranteed work. Lots of people talk about benefits and hourly wages and other things, but what I hear from them and I hear from my circle of colleagues is that they would like guaranteed work.

I made reference to the fact that there are different workers in the clients that we're serving who get substantial—you could never send the same worker in, and in fact, Sandra will talk about our continuity scores. We track continuity for our clients. We have very high continuity, over 90%, so my clients in Toronto are not getting different workers every day. Again, in a place like Toronto, I've been able to work locally to develop neighbourhood care teams where we've tried to—I can't directly impact the wages and the benefits of the personal support workers, but I've been able to do a lot locally to indirectly influence their working conditions.

M^me^ France Gélinas: Why can you not? You sign the contract. You give them the money.

Ms. Stacey Daub: Sandra, do you want to talk a little bit about contracts?

Ms. Sandra Coleman: Yes. As you know, we don't employ the personal support workers, so any of those levers, if I can call them that, that would be able to directly impact on wages, benefits and working conditions aren't open to us. But I agree with you: It's not that we don't have a sphere of influence. Part of that sphere of influence is, what is the model of care and how are we supporting our patients with personal support work?

I have also heard in South West that moving forward with something like Home First was not only of tremendous benefit to the people who were able to then remain at home instead of in hospital or long-term care, but the personal support workers love that model because it offers four- or eight-hour shifts for them that give them that greater stability of employment. Furthermore, they have the opportunity to engage even more intimately and develop even stronger relationships with their patients.

M^me^ France Gélinas: I get all of this. I also come from the field, so I know how PSWs work. Where I live, we say that Home First is finally enough home care. We don't call it Home First; we call it "Finally, enough home care." It only works 30 days, and after 30 days you're back, begging for more hours.

I'm interested in your negotiating contract and your sphere of influence. So there are no levers; you will dish out billions of dollars of contracts and none of this can be used to get what everybody who works for CCAC has: a respectful job.

Ms. Sandra Coleman: I was going there next, in terms of sphere of influence. Another sphere of influence is regarding our contracts. While we are not the employer, there is an opportunity to understand how we describe that work and how we create the conditions for success, because personal support is such an important part of the care that we provide for our patients.

In 2006, for example, that was the last time that there was a whole strategy, working collaboratively with government, with our service providers and with CCACs to understand that there are inequities in this important area, and what are the opportunities to have a strategy that would make improvements of a very tangible nature, exactly as you're describing. That's when, for example, a personal support worker minimum wage was introduced that is higher than what was the general wage at the time.

We have advocated since last fall that it's time for us to address again that issue—it's been since 2006—and to have a renewed strategy that would not just look at the minimum wage, although I do think that's an important piece of it, but also to understand what other elements could be brought to bear that we could work on collaboratively with our service provider partners who are the employers.

M^me^ France Gélinas: Can you name me some?

Ms. Sandra Coleman: Well, the last time, there were specific conversations around travel time, in terms of mileage as well as the time spent in the car travelling. That's a really important piece, especially where I'm from, which has a lot of rural areas, and for you as well, where the distances are quite large. Pensions and those kinds of issues—I think the potential is there for that type of comprehensive strategy to exist. Our suggestion is that it's not just time to update the strategy, but that it's essential to do it fairly soon and to tackle it on that broad basis, but collaboratively, with our service providers. It won't be able to be just a quick change to the minimum wage, I don't believe. I believe that's a necessary piece of it, but we believe the other components are going to take the employers as well as the CCACs to come together and understand how we can make change.

M^me^ France Gélinas: In the last eight years, has any CCAC been successful in using some of those leverages to effect change?

Ms. Sandra Coleman: Certainly when new services are being rolled out, we have the opportunity to understand: What are the right contractual arrangements that would support that?

I'll go back to Home First, but for a different reason. When we rolled out Home First in the South West, instead of having that be volumes that would be open to all of our current personal support workers, we did a separate and distinct call for interest from our providers because we wanted them to commit to a specific training program, to enhanced continuity requirements, to the services in terms of shifts that would be available, and that would also—because this was entirely new volume, what was their recruitment and retention strategy?

M^me^ France Gélinas: And how did you put that into a contract?

Ms. Sandra Coleman: We were able to put that into a contract with the provider that was successful in that, and it means that our Home First volumes are with those

terms and conditions that enable us to continue to hold the provider accountable for that recruitment and retention and training that's really important to our patients.

M^me^ France Gélinas: Why is it that changing those terms and conditions in the existing contracts hasn't been contemplated, done or tried?

Ms. Sandra Coleman: We moved all of our contracted service providers to a similar contract in October 2012. It was for a two-year period; it is coming up this October. We are actively considering now: What are the necessary changes and issues that we need to be collaboratively discussing with our contracted providers?

M^me^ France Gélinas: So what happened in 2012?

Ms. Sandra Coleman: All of our providers were moved to a similar contract template with the same terms and conditions of employment across the CCAC.

M^me^ France Gélinas: So did you see an improvement in the PSW working conditions?

Ms. Sandra Coleman: In the South West, we track the issues around continuity. We track issues around missed visits, around referral acceptance. There has definitely been an improvement, I would say, over the last year in the case of the South West.

Ms. Stacey Daub: From my perspective, and again in our earlier remarks, this is a public policy discussion. I think it goes well beyond the CCACs in terms of thinking of a health human resource strategy for home and community workers. The environment has changed. It's a much broader discussion that needs to occur. I don't think the CCACs themselves—based on the very basic fact that we don't directly employ. We've recently had confirmation of that; that we are not the employers. We don't have the ability to directly impact their wages and benefits. There are many countries that have grappled with this.

Contracting services is not unique. It happens across Canada, but it should come in a way that makes the most sense to the patients and is fair to the workers who are in it. I think we, as a sector, would welcome that discussion. There are many things to think through. There are countries who have moved to standardized rates for services that are set at the provincial level that make sure that people are adequately being compensated for the work they do. There are other ways that others have done it in terms of pooled benefits. There are all kinds of opportunities, but from my perspective it is a public policy discussion that needs to happen with government, which we would be part of and which I think personal support workers themselves should be part of. In the interim, we have a responsibility, where possible, to try and improve the working conditions. I can tell you, I do that every day in my job.

M^me^ France Gélinas: Can you give me an example where you have been successful?

Ms. Stacey Daub: I can give you many examples. I gave the example of the development of neighbourhood care teams, so that an individual personal support worker—a team. They're not working one-on-one going to different houses; they're working as a team of workers. They have a nurse with them and a care coordinator in a building in a neighbourhood, so that they can meet daily. They can share and exchange support, so that they don't have to travel as far, so that they can get more hours in a row.

We have also developed an ethical decision-making workshop and processes. We have a full-time ethicist. We do more work with personal support workers than any of the other professionals who work in the system because they want it. They're the ones who come out to the sessions—we pay for those sessions—where we work through the very difficult situations, the morally—the things that are most difficult for them.

We do quite a bit of work.

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It would also be my expectation that Laurel and care coordinators who are working are thinking about the personal support workers and the way that they do their care plans. I know that they don't send people out at night. I think that it is an organizational responsibility to care for the other care providers who are part of our team and to do what we can have a part to do, but there are other things that need to be discussed at a broader level in the province that are public policy decisions that we should contribute to. But the personal support workers should have a big voice.

I will add one more thing. I am working with my LHIN; we're doing a review of what the opportunities are to have pooled benefits and other things for personal support workers, and what the policies would look like. I often look at policy issues, so in many ways, am I thinking about it? Is it frustrating that I don't have direct control? I would love to make a difference in every personal support worker's life tomorrow. I can't, so I have to use the levers that we have available to us to try and do that.

M^me^ France Gélinas: Okay. We're still going to talk about compensation, but this time at the other end. Executive compensation has been a very concerning issue. It has hit the front page of the papers, for all the wrong reasons. Can you explain to me: What is the process by which CEOs receive their salary increases?

Mr. Barry Brownlow: I'll speak from the perspective as the board chair of Hamilton Niagara Haldimand Brant. There are a number of functions that the board is responsible for. One is to make sure that there's a good CEO in place, and that has a number of different components to it. The first component is to make sure that the job is done and that the job is done well. That's primarily a system of performance reporting that in our CCAC takes place as an interface between the CEO and the board on a quarterly basis. I can give you some sample objectives in performance management.

M^me^ France Gélinas: I'm familiar with those.

Mr. Barry Brownlow: But then the wage, the component that is a fair and equitable wage, is based on a comparison of what the wages are out there, and that takes into place what it would cost us to replace our CEO if some accident happened to her or lightning struck or

she just took another job. So we have to have a market-based comparison. We take our time doing that to make sure it's fair and accurate. That's the part where we have to live with the numbers, because the market is the market. I would love to get gas at 90 cents, but it's $1.25.

M^me^ France Gélinas: How do you reconcile the fact that in 2008 we had the recession that didn't know when to end, that the government sent out directives that salaries were to be frozen—and certainly the people at the lower end saw their salary being frozen, but not the people at the top. How do we reconcile that?

Mr. Barry Brownlow: We don't. They were frozen until 2012—is that the right year?

Ms. Stacey Daub: Yes. I think France wasn't here when you made your original statement with that content from the beginning.

Mr. Barry Brownlow: That's okay. You asked the question; I'll answer it as best I can. They were frozen in 2012 and after that time they weren't, so the market forces started to prevail. We need a CEO. We need the CEO to be paid because we would have to replace the CEO at those wages.

M^me^ France Gélinas: So you're telling us that all the CCAC CEO salaries were frozen from 2008 to 2012?

Mr. Barry Brownlow: I'm just going to ask for confirmation, because some of those times were before my time.

Ms. Sandra Coleman: It was 2010.

Mr. Barry Brownlow: It was 2010 to 2012.

M^me^ France Gélinas: What was put out in the paper where what was published under the—not freedom of access, but the—

Mr. Barry Brownlow: Sunshine list?

M^me^ France Gélinas: —sunshine list, where we saw the salaries continue to go up through 2008, 2009, 2010, 2011, 2012. They continued to go up. What am I missing here?

Ms. Stacey Daub: Maybe I can give an example. I can give a personal example. What they did in my example: I was the first person to be put in the Toronto Star. They took my predecessor, Camille Orridge, who left the organization halfway through the year, and they compared her salary to my salary of four years later. So it gave a very distorted view of what actually happened.

M^me^ France Gélinas: So what actually happened?

Ms. Stacey Daub: I was hired in 2011 as a new CEO at a salary. The predecessor on the sunshine list only counted for a half or three quarters of the year for my prior—you were comparing apples to oranges, the point being that I don't believe everything I read in the paper. I think there was some accurate information in terms of how the salaries changed.

Barry, in his address earlier, indicated that our boards all observed the freeze that was in place for the two-year period, and that happened. But I can't speak for other—I can only speak for my own experience. So it's a very distorted view, what was in the paper.

The only thing I would add is that we have talked, as a sector—we are very interested in the public policy debate that's happening around executive compensation writ large in terms of the public service, and I think we feel quite confident that if anything was put into effect, we would be happy to fall into that process.

M^me^ France Gélinas: Okay. A change of path before my time runs out: You've all seen the report by RNAO that suggests that the contracts for the service providers be with the LHINs rather than with CCACs. You've explained a little bit to me as to the limited leverage you have on those contracts—to effect change for PSWs, anyway. So what would be so wrong in having those contracts handled by the LHINs? They already handle thousands of them.

Ms. Sandra Coleman: I'm wondering if it's sort of a two-part answer, if you don't mind, on the RNAO, because I think Dr. Martino would have some perspective, since part of the RNAO model involves primary care as well.

I'll just start by saying that from the CCAC perspective, part of the RNAO's suggested model would be devolving. It isn't just that the contracts shift to the LHIN. It's that then the care coordinators attach instead to the individual primary care practices. In the case of South West, where I know the numbers best, that would be 700 to 800 disconnected and separate family practices.

On behalf of a patient, if you look at it through a patient's lens, I think some of the challenges that come from that are that if you don't have a family doctor, how do you then gain access into home care? That's not very clear.

Also, if I'm thinking about being discharged from hospital, there are literally hundreds of discharges a day. In a given month, there are over 3,000 discharges out of some of our larger hospitals, any one given hospital. So if you imagine LHSC, London Health Sciences Centre, with hundreds of discharges a day going to hundreds of different primary care practices, that hospital would then need to be interacting with dozens, if not hundreds, of disconnected primary care practices.

I think the advances that have happened since the new merged model took effect on January 1, 2007, that has gone a long way to improving the consistency of care—if you're getting discharged out of LHSC, whether you live in Huron county, whether you live in Oxford county or whether you live in London, you have access to the same level of equitable home care services, all through a single point of contact within the hospital. That would become impossible under the model.

But I think the primary care voice is very important on this, if I may.

Dr. Frank Martino: Are family doctors ready for another layer of governance and organization? I don't think so. I don't think that the single-shingle physician has the resources, the understanding of care coordination, to absorb a care coordinator within their practice. I think physicians work better if there is central care coordination and in developing a structure so they fall and drift out of their silos into a better integrated system.

There are care coordinators in practices. They work very well, especially in larger practices. Do you have the volume to support a single care coordinator in each practice? I don't believe so. Can you do it centrally and in a coordinated fashion through a community? Absolutely, and it's being done very well in my LHIN.

My care coordinator visits once a month. We go through our list. I actually look forward to that day, because it allows me to spend time and discuss my patients in a more comprehensive manner, in a more coordinated manner. It also allows me to discuss with that care coordinator other issues that I may have that involve other patients who probably would fall through the cracks if I didn't have that dedicated care coordinator.

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M^me^ France Gélinas: How do you get paid when you spend a day or half a day with the care coordinator?

Dr. Frank Martino: The actual fee schedule allows for that.

M^me^ France Gélinas: So you bill OHIP?

Dr. Frank Martino: Yes. You don't bill at the rate you do for managing a patient within your clinic or in the emergency department or in the hospital, but the remuneration is sufficient to—but it's not really the remuneration, France; it's actually the impact you have on your patient during that period of time.

M^me^ France Gélinas: I agree 100%.

Dr. Frank Martino: When I pick up my day sheet and I look at that patient, I go, "Oh, my God, they're back. I can't do anything more," and you feel that degree of—your heart drops. It's that heart-drop moment you feel, "I need some help here," and if you're not on a family health team and you're a physician in the community, that virtual team is really something important in your day. I can guarantee that physicians would go to those care conferences and not get paid, because it really does relieve a lot of the stress you have in your day.

I mean, you put out easy fires throughout your day. It's those five or six patients, the five or six complex cases, often seniors, that you struggle with, and it's that navigation, that care coordination, that makes a huge difference.

M^me^ France Gélinas: So for physicians who work within an interdisciplinary team practice already, the model works is what you're saying—

Dr. Frank Martino: Not necessarily—

M^me^ France Gélinas: —and for a fee-for-service solo physician, then it doesn't?

Dr. Frank Martino: I think in a fee-for-service solo physician model, if you have central care coordination and you have that care coordinator visiting that single physician office, that works well too.

M^me^ France Gélinas: That works good?

Dr. Frank Martino: You just need to have a roster of physicians that you're dedicated to. So Sandra Hastings comes to my clinic that has 17 physicians, but she goes to a few other groups. It's easy when she comes to the 17 physicians, because it's on one site and she can devote a day or two—you know, we have rosters of up to 40,000 patients—to deal with those patients who require home care. But she'll go over to the physician across the street who has a roster of 2,000 patients and deal with their patients. It is, you know, on preplanned and appointed times that they review that case.

M^me^ France Gélinas: But you still didn't answer the first part of my question. If you're already in an interdisciplinary team setting, so you already have a care coordinator, you already know the patients from cradle to death, you already have the family history, you already know where they live, who supports them, who brings them to their appointments, is the son or daughter abusive or helping? You're a primary care provider; you know all of that already. The CCAC knows none of that.

Dr. Frank Martino: In fact, we don't. So if I visit that home, I would know a lot of those things; if I don't visit that home, I wouldn't. The care coordinator does know that. They actually visit. They get those reports and they feed them back. They'll say, you know, "Mrs. X is having struggles in just navigating her home. She will no longer be able to make it up the stairs to the second floor. Maybe we should look at moving a bed downstairs for her." I wouldn't have known that.

My family health team does have interdisciplinary care providers. We have dietitians, we have NPs, we have social workers, but we don't have that connection to the home and to the community, and we don't have access to the number of other baskets of services that the community care access centres do have. We have more than non-family health teams do, but definitely we do not have access to that basket of services, and we don't have the knowledge to navigate them.

If you look at the physician who is not part of an interdisciplinary team, their knowledge of those community-based services is much lower. I thought I was someone who could navigate: "Oh, God, I know what's out there. Hell, I'm a family physician and chief of the department at my hospital." But when the care coordinator came, I was in awe at the number of services she could get my patients into, the day programs I wasn't aware of, and that was just to name one of many.

M^me^ France Gélinas: You still haven't convinced me that having this person with this knowledge—I come from a community health centre. I can guarantee you that the nurses in my community health centre knew every day program and who drove who where, and will the dealership pick you up if you live in Chelmsford and bring you to your appointment? They knew all of this, so I know that this exists successfully within the primary care system. It doesn't work so much for solo, but this knowledge and skill that you've described—why does it have to be attached to a CCAC? Why is it not attached to the people who have followed these patients all along? That's called primary care.

Dr. Frank Martino: I think we have a collaborative relationship, and I think that that collaborative relationship works extremely well. I can speak from my own experience: Members of my medical community would feel uncomfortable having another layer of bureaucracy

within their office to manage, another level of governance—

M^me^ France Gélinas: So if somebody visits, it's not called bureaucracy? When does it become bureaucracy?

Dr. Frank Martino: When I have to worry about its function within my own office, in my own clinic.

I tend to disagree with you in the sense that community health centres know all of this. There are patient navigators and care coordinators in a lot of community health centres. There are not very many in family health teams, and definitely not in family health groups and in three- or four-physician offices.

Do you have the capacity in those smaller groups and physician offices to support a care coordinator? Probably not. Would it be done efficiently that way? Absolutely not. If you had someone centrally, with the skills and the organization behind them, it would be much more efficient and effective.

M^me^ France Gélinas: Okay. Because my time is running short—

Interjection: You've got about a minute.

M^me^ France Gélinas: Oh, damn. I wanted to talk to you about placement into long-term-care homes. We still get a ton of complaints on people in hospitals being pressured to be put on the lists of long-term-care homes that they don't want to go to. This pressure is often applied by your care coordinators who work in those hospitals, to get them out of there. It's a huge issue. I just wanted your view on it, and where the CCACs fall when it comes to having the long-term-care home of your choice rather than vacating the bed as soon as you can.

Ms. Stacey Daub: I can only speak for Toronto. I have something at the board level all the way through the organization that's called "supporting people in their choices." It's a board-level policy. My expectation would be that every care coordinator supports the client in their choice. If they choose not to have five names on their list for long-term care, they do not need to have five. If they choose not to go to long-term care, they would not need to go to long-term care.

Can I say that our hospital coordinators don't get immense pressure from everybody involved related to the fact that they would like to see clients pick homes with shorter wait-lists? But it is our job, and it is a critical job and a job that should be supported, for the care coordinators to have an independent voice that supports the client in their choice. So I feel confident in Toronto that we do not force people to add lists. We do provide counselling and support, but it is our job to support them in their choices.

The Chair (Mr. Ernie Hardeman): Thank you. Thank you very much. That concludes your time.

We'll now go to the government side. Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Chair.

Thank you so much for coming and bringing the team to give us a different perspective from each of the speakers. I think this was very useful.

It took me back to the late 1970s, when I was in practice here at Women's College Hospital. I visited 423 Yonge Street one day a week with a home care nurse, and we used to see the cockroaches in the apartments and so on.

Mr. Mike Colle: Any bedbugs?

Ms. Helena Jaczek: There were probably bedbugs. We didn't see them. I don't remember them hopping.

Having said that, it makes me feel that some things are very similar. What is different now, and why we are talking so much about CCACs even though this is a LHSIA review, is that, because of the transformation occurring in health in Ontario, we are obviously putting this huge emphasis on home care, much more than we used to, and there's an additional layer of complexity in terms of the type of care that is provided to patients.

I'm going to start off by talking about patients. Stacey, on page 8, you talk about how health system leaders, experts and policy-makers should be consulting with patients, and you've given us a few suggestions of things that you have heard. Do you formally—each of the 14 CCACs—do patient surveys? How do you do them? Is there a common template across Ontario, and do you have those results in some sort of tabulated form?

Ms. Sandra Coleman: Is it okay if I answer?

Ms. Stacey Daub: Sure.

Ms. Sandra Coleman: Yes, the CCACs work together. We use the same patient-engagement tool. The tool is by the phone, as opposed to a paper-based survey. That enables issues around translation and speaking with, potentially, a caregiver instead of the patient, if there's a substitute decision-maker involved. We have learned from practice that doing a phone-based survey seems to be able to get the most helpful information.

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Province-wide, our patient satisfaction scores of those who rate our care as good and excellent are well over 90%. In South West, our scores are in excess of 94%. We report on those publicly. Starting on April 1, our patient satisfaction scores will be part of the quality improvement plans that all CCACs will be posting through Health Quality Ontario, and so all of that information will be public.

There's a breakdown, as well, on some of the scores with those same patients' evaluation and rating of the service providers with whom they are connecting in their homes. So it will have multiple dimensions around their home care experience.

If I may add, it's also important, we all believe, to not just have that quarterly process happen, but to have true patient engagement, and so, many of us have patient councils or advisory councils. Many of us are delving much deeper into understanding the patient experience. That can be by having focus groups, but it can also be much more meaningful than that by involving them in the recruitment and the retention process and being part of interview panels, as well as participating in discussions around—if we are going to consider a new pump, for example, to be used with some of our children with complex medical health needs, we should call together a group of the parents of children who are using that pump

and understand and get their input into what's working and what's not.

Ms. Helena Jaczek: In terms of collating this information, again, one of the examples that you gave was that parents of children with very complex needs have suggested, is there some potential of some—I don't want to put words in your mouth, but it sounded like some sort of group opportunity where there would be some provision of service where, perhaps, whether it be for respite care or permanent—that that was a concrete example where you've heard things like that. You've heard about flexibility around funding; this is the dollar amount potentially that could be used in terms of your needs, but it doesn't quite fit.

Have you collated these types of recommendations in some sort of document that we could access? This is what I'm trying to get. You've given us a couple of examples, but what we would really find very useful, I think, and if it's possible to have that kind of patient input—the raw scores of 84% satisfaction, I'm not too interested in that. I'm talking much more about concrete ways that we can gear the system more towards patient need. Do you have that, and could we get it?

Ms. Sandra Coleman: Part of the work that we have done across 14 CCACs has been, similar to some of the some of the questions that Stacey framed in her presentation today, to understand what are those big questions that we need to address in order to meet the growing demand for home and community care and how to do that as effectively and efficiently as possible.

So we have released a series of four discussion papers, called Health Comes Home, that try to frame what some of those big issues are, and we are in the process now of reaching out to a whole plethora of stakeholder groups, including patients, to engage them in this debate. We have the four papers that we can share that frame the discussion, but we're in the midst of gathering the information and collating it. We don't have that ready yet; we're in the midst of that engagement process. One of the papers is specifically geared around aging and the seniors' population, as well as palliative care. One of the papers is around children's care and mental health issues, because those are both really important.

We hear from our patients that they want to have a say in some changes that would make their care experience better, so we're engaged and embarked on that work, and would be pleased to share that with you. It should be available within the next three to four months.

Ms. Stacey Daub: I was just going to add to that. I have a particular interest in children with medical complexity, and so I work with the Provincial Council for Maternal and Child Health, and we have done a large-scale engagement with parents about their thoughts and needs. Again, it's a whole different generation of parents, so we're collating that.

I think there are multiple ways. The one around the flexibility and choice, I think, is one that we really need to be thoughtful to. I know that Dr. Sinha put it in his report. I think there are some real opportunities in other jurisdictions that we could learn from in terms of that flexibility and choice, and would very much—again, I think the CCACs would like to be a part of that.

We're just finishing another policy paper locally in Toronto about flexibility and choice and what some of the policy options might be, and we'd be happy to give that to government.

Ms. Helena Jaczek: I guess, then, that leads to the question of process. You're busy working on all this. Do you share this with the LHIN? Did the LHIN ask you to do it? Where does the ministry come in? Explain the process to me.

Ms. Stacey Daub: My perspective is that every health system leader and health system organization has to contribute to thought leadership and change. I have a role, as an individual CCAC, to listen to my patients and to try and bring those issues to the fore and advance them, sometimes directly with my LHIN, sometimes with the ministry, sometimes with my association. I use all of those channels actively.

My LHIN—I work with the Toronto Central LHIN—is very responsive. We partner on many common issues. Not only do we partner, but we partner with our hospital partners, our community health centres and our primary care practices on particular issues. At other times, we work directly with government on issues that come in a different form. There are a variety of ways, but all of those channels are particularly important.

I guess the question is, how do we talk about the most important policy issues in home care so that we are really on the front road of strengthening it for the future? I think it's a good time now. I think people are talking about it, but I would prefer to have those conversations—

Ms. Helena Jaczek: What I'm really getting at here is, thank you for acknowledging —you have it somewhere in your statement—that if we were to design the system now for home care in Ontario, we wouldn't necessarily do it the way it is. We're interested in positive recommendations coming from the field. I would say I think it was our impression around this table on all sides—the three parties here—that there was very much of a defensive attitude that was coming to us as we started this process, that everything was perfect. So I'm glad to see that there are some concrete recommendations coming from you, because that's what we need to hear.

We're putting a lot of money into the whole community health piece, and we want to get it right. I mean, this is an opportunity, as we build the community side of things, to get it right. I think it's really important to acknowledge that every tax dollar needs to be put to its very best use. Certainly, from our perspective, there's no need for any sort of feeling of defensiveness. It's simply that we need to get at the right answers.

Now, I want to get fairly specific on contracts and contract management. You mentioned a contract template with your service providers. Where did that template come from?

Ms. Sandra Coleman: The CCACs work collaboratively with our service provider partners to understand

the current contracts that were in place and then to understand what changes are necessary to—in 2012, when we moved to the existing contract that we're on, the world was very different then. The nature of the expectations and volumes and everything were very different from what they were when the prior template had been agreed to.

That is a fully collaborative process with our contracted providers. Tables are struck for the purpose of hearing everyone out and reaching consensus on what those contracts need to look like and what the changes need to be.

Ms. Helena Jaczek: Again, it came from within the CCAC world. It wasn't the LHINs getting together and saying, "Henceforth, you, CCAC, will use this type of a template"? That wasn't how it worked at all?

Ms. Sandra Coleman: No. The LHINs had a voice and were part of the engagement process to make sure that—for example, there needs to be a cascading impact so that the expectations that LHINs are held to by the ministry, in terms of what their performance indicators are and which ones of those really come to life in the home care and CCAC world with our contractor providers—to make sure that then there's a cascading in terms of our accountability agreements with the LHIN and also our contracts with our contracted service providers.

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Ms. Helena Jaczek: In terms of your contracts going forward, you saw that we were puzzled about the single electronic health record, because obviously in our offices we hear that things are pretty much all over the map and people are falling through cracks and so on. Have you not included that every service provider will start using the single electronic health record? Wouldn't it be very easy to insist upon that as part of the contract?

Ms. Sandra Coleman: I wonder if it's a difference between the IT platform that we have in place with our contracted service providers and the experience in the home of the constituents, which is where you're hearing the experience. As Stacey said, we have a pretty complete and robust not just CHRIS system but eHealth connectivity with our contracted providers in which, as the RAI assessment is done by our care coordinators—you may know about that assessment that's done in the home—that is electronically transmitted to our contracted providers, along with the information that describes when services need to begin, the nature of those services and the outcome and goals that would be expected. That's all transmitted electronically.

Where the reality is different for the constituent is that, in their home, there is no electronic health record. There can't be one.

Ms. Helena Jaczek: But surely your care coordinator has an electronic—

Ms. Sandra Coleman: She has a BlackBerry or some type of electronic handheld, but that is different. The client can't get in and see that. So many of us—for example, in South West, we have a chart in the home, a binder. It's a simple binder. We actually ask our service providers to chart as they are in the home, to use it as a communication tool with not just our clients and patients but their family members, who may not always be in the home. I know when my dad was receiving care, the first thing I did when I came home on the weekend to visit was to look in the binder and see what had happened. Sometimes they were leaving questions for me to answer as the daughter and substitute decision-maker, and sometimes I was able to write notes back.

We are moving forward very quickly with an electronic reality that is better than almost any other part of the health care system. Where we encounter the reality of coming to a ground halt right now is in the home itself. How do we create a connectivity that would enable our clients to be part of the circle of care in an electronic way? That's where we really need to get to.

Ms. Helena Jaczek: I think that would be ideal. Certainly, as has been said, there is no question—in our community offices, we hear about people being discharged from downtown Toronto hospitals. They move up to Markham, wherever, and people somehow don't get the care they were told they would get etc. So something is just not being coordinated.

Ms. Stacey Daub: Maybe I'm in the best position to respond to that. My organization transitions 68,000 people every year. I'm the person responsible for part of those transitions. I have over 100 CCAC staff who work in the hospitals. I would say to you—and I watch the adverse events and what happened—that we have very few situations where a client doesn't actually get service. What is more likely is that it is a reflection, I think, of system issues, either that the services that might be available in that community are hard to get to, that there's not a nurse available or a physio available, that the service levels are different in that community, or, quite honestly—I think of the most recent one that was in the paper. They had never been referred to us. So it was hard for me to lose them in the cracks when no one had ever actually asked me to do the transition for that patient.

So I think some of the things that you're speaking about are broader issues of how we communicate from hospital to home, whether it's hospital to primary care—and Frank can probably speak to the complexity of that—or how we communicate between CCAC and hospitals.

I feel like we are doing a much better job. For example, in Sunnybrook, which would likely discharge to many of your areas, we have moved to an integrated discharge planner for complicated clients. We no longer have a social worker, discharger planner and multiple people coming, because it's confusing for people. We have an integrated discharge planner who starts to meet with them from the time that they arrive—so much earlier—and develop a relationship, because it's partially relationship-building, so that at the end of the day they have a much better sense of what's happening and it doesn't come as a surprise.

I think there are a lot of other things that we could do, particularly around hospital discharges. They're scary. It happens very quickly, and there is quite a bit of work

happening between primary care, I think, hospitals and CCACs. We need to do more, quite honestly, in terms of those transitions because they're really important.

Ms. Helena Jaczek: And there are a very large number, and, of course, what we hear about are those few. The capacity issue leads to your point and your recommendation in terms of looking at capacity across the province and having some sort of a plan. So I certainly understand—

Dr. Frank Martino: Just to add to that about transitions: Transitions are something that—25 years ago, when I managed my own in-patients, there was no issue about transitions. I had spoken to home care; I knew exactly what the plan was. I didn't have to do a med reconciliation because I ordered those drugs and I knew very well what they were going to be. As we've moved into an electronic age—because I didn't have an electronic medical record back in 1990 but I do have one now—I think it is a systems issue and it is an issue with regard to eHealth and where we're moving.

I think we're making big strides. If I look at my own community, we had a 17% uptake of an electronic medical record just three and a half years ago. We have an 84% uptake now. I think we all have a hunger to get this kind of activity and for it to happen quickly. We are moving forward with very innovative ways of communicating discharges: births, deaths and discharges for patients in the community care access system.

In our area, we have an enterprise fax system. Physicians are faxed that discharge summary, actually, before the patient is discharged. We have an understanding with our hospitalists and our physicians who provide in-patient care that they need to dictate that within 24 hours. Most of them dictate it, knowing that a planned discharge is going to happen, before the patient leaves. It's actually in my inbox before the patient makes that appointment.

I think we're struggling, but we will get there—Hospital Report Manager, GTA connect; a lot of innovative projects are just on the horizon. OLIS is a reality for most physicians. We can get lab tests. Getting an integrated radiology information system so that I don't have to repeat ultrasounds and X-rays when a patient shows up in an emergency room and I'm working a shift and I get really frustrated with the fact that I'm now having to duplicate a service—I think that those are things that are going to improve the way we connect.

I can say that when a patient of mine is discharged from CCAC service, I get an indication that they are. If I'm not happy with it, I pick up the phone and I get a warm body at the other end where I can complain. I think we're getting there. We're just at the horizon of things now, starting to accelerate. That snowball is going to get much larger.

Ms. Helena Jaczek: That's very reassuring. Our bedbug specialist has a question.

Mr. Mike Colle: I think bedbugs are like the symbol of a lot of the complex challenges we have in providing good health care, especially at home. It's because it's all the determinants of health and poverty and mental health issues. I think the bedbugs and cockroaches and all those very resilient animals basically manifest how difficult everybody's job is. But I will ask a bedbug question in a second.

I just want to commend Dr. Martino for bringing to light the numbers here: 40,000 patients for 17 doctors.

Dr. Frank Martino: We have 18 now.

Mr. Mike Colle: Eighteen doctors.

Dr. Frank Martino: Yes. We unfortunately had one of our partners who passed away rather quickly after his last day at work. I still remember, back in late September, I said, "Mike, you're looking a little"—

Mr. Mike Colle: Who was that?

Dr. Frank Martino: Mike Dennis. He had been in practice for 49 and half years. He looked a little pale; he had a bit of jaundice. The next week he got it investigated. We found out that he had some liver failure, and about two months later he passed away of liver cancer. That physician had 2,200 patients. We have been very successful because we have a residency program to draw on a former graduate from our program who has now taken over his patients. Otherwise, we would have had 2,200 orphan patients. The group was very good in absorbing that patient roster.

So 18, yeah—18 and about 40,000.

Mr. Mike Colle: I think it just makes me be reminded of how many pressures front-line health care providers have in this day and age. It's just daunting. I was in my doctor's office last week, and just the phone ringing—he works in the basement of his house, but he works out of North York General too. He had just delivered a baby and then he came back. I said, "I wouldn't want your stress, Doc. I wouldn't want your stress." I don't know how you guys do it.

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In this committee, we're looking at improvements and different directions, and I think sometimes we don't think outside the box enough and we're not allowed to think outside the box. We just beat up old boxes all the time. But anyway, the one thing I had is—I'm dealing with a case right now where there's someone suffering from terminal cancer. The person is getting chemo, comes down here to Princess Margaret, goes home, is not able to really drive anywhere or go grocery shopping etc.; has some home care; but luckily, his sister is there taking care of him. She has basically moved in. Therefore, she is providing the transportation, the shopping, the cooking, the cleaning, the basic little supports that you need when a person is suffering through cancer in the late stages. I'm just thinking: Since you provide home care through contracted services, why not look at perhaps a system whereby, if there are caregivers who are outside the contracted services—that could be a family member, a friend, a relative—who are willing to basically provide some of those support services that you need—because it's not just what the nurse does; you have to clean the bathroom and you have to cook for the person and you've got to give the person company.

I know that they have this system in Italy where basically, if there is someone who decides that they're going to be a caregiver, there is compensation that goes to that person who provides that care at home for someone who is ill. So why couldn't the CCACs be able to, also, in order to expand the service provided—because if there's someone willing to do that, it would take pressure off of the demands you have, as doctors, as PSWs, as care coordinators. Why not enhance the system, because I think in some ways there might be a savings down the road, or else that person will end up in a long-term-care home; they'll end up in a hospital; they'll end up sicker, so you'd need more hours of care from the contracted service. Could that possibly be administered or examined as something that might work?

Ms. Stacey Daub: Absolutely. I think it's one of the public policy decisions you could make in terms of flexibility and choice. There are, in fact, many jurisdictions across the world that do that very thing in terms of supporting caregivers, sometimes even paying caregivers to provide the care and support to the individuals. So I think it is that kind of out-of-the-box thinking that we need to think about.

The one thing I want to correct: Home care is more than our contracted service providers. When we go in to a client, our job is to bring all of the resources to bear. So sometimes, it is actually helping—we can't pay family caregivers right now, but it is counselling about their role, and helping them to be better caregivers. We have a relationship with the Reitman Centre at Mount Sinai, and we train all of our caregivers on how to actually engage with caregivers and train caregivers. They have a role of helping caregivers be better caregivers or more supportive caregivers. They have a role to bring community support services. Sometimes they have a role to help someone get a wig because they want to go back to church and that's the most important thing. This whole focus, to me—I've always wanted to put this on public record. Years ago, my husband wanted to get me a t-shirt that said: "Home Care: It's More Than a Bath." It's far more than that. It is creating a village of care around individuals, and that is our responsibility and that is what I think we should be held to account for, and we need the flexibility to do that.

Mr. Mike Colle: But couldn't the village of care include—

Ms. Stacey Daub: Absolutely. It should include professionals, non-professionals and family caregivers.

Mr. Mike Colle: Is it possible to manage, or am I dreaming in Technicolor?

Ms. Stacey Daub: No. It would in fact be easier because, in my opinion, you need to bring—many family members want a part to play. If there were ways that they wouldn't lose income and could be remunerated to play that part, they would happily do it. Some simply can't because they have jobs and they are the primary breadwinner. So there are many ways to build that village, including unpaid caregivers and finding a way to potentially compensate them. Right now we do have policies and things in place around family caregiver leaves and so on; they're just pretty limited.

Mr. Mike Colle: Not enough.

Ms. Stacey Daub: If you think about the people whom we're caring for, years ago it was for a short period of time. The interesting thing to me is, our length of stay is going longer and longer and longer because people are managing at home and they want to stay at home. So it's not going to be this short period of time where you're—I think of my own father, who is 88. People are living longer and staying at home longer, and we are going to have to be more creative.

You're going to hear from Dr. Sinha later, I think. He's done all kinds of research and has talked to people across the province. He might be able to give you some other good insight on how to think outside that box, because that's what we have to do.

Dr. Frank Martino: In Italy—you make a very good point—I have two aunts who have been taken care of through that particular system, where a younger senior, who is retired, is paid to care for a much older frail senior, and it worked very well for almost 10 years.

Mr. Mike Colle: Yes. I don't know if there are Ministry of Health people here, but I've been trying to push this idea, but I always say—and it's, "We've got to deal with this."

Anyway, thank you for that. Maybe I'll get back to you for a letter of support for my idea—but just to consider it anyway, because I know these things are not easy to deliver on the ground because it always needs coordination and oversight and so forth.

There's a cost to being a caregiver. Whether it's the PSW or whether it's the family member, it's gas, transportation, clothing, time off work, whatever it is—there is a definite cost. Sometimes we don't incorporate that cost, and we don't appreciate the time and effort and compassion that people can give to a person who's ill, and I think it might enhance that.

Just getting back to the bedbug thing, I was going to ask the care coordinator if she could—Laurel, I think it is. Right?

Ms. Laurel Stroz: Yes.

Mr. Mike Colle: So if you go into a home and you see the situation where obviously that person cannot take care of themselves—there's obviously hoarding or there may be bedbugs, cockroaches or all kinds of things—what can you do, outside the medical situation, to help them deal with those not directly health-related issues but obviously manifestations of other health-related problems? What would you do or how can you help those people in those conditions?

Ms. Laurel Stroz: Sure. I can just speak generally to that because every client has a very unique situation and would require a unique service plan.

I worked specifically in the Regent Park-St. James Town community, and there was a great deal of bedbugs and a great deal of cockroaches, and social/environmental issues in conjunction with other very poor social determinants of health.

It takes a lot of thinking outside the box in order to be able to provide health care in those circumstances. So my role as the CCAC care coordinator really was to partner with all of the other agencies that are able to provide supports, so volunteer agencies, cultural-religious agencies, Toronto Public Health and their bedbug team, and the local St. James Town Health Centre. We worked as a team and developed individualized service plans for each of those clients who would have very high health care needs: very frail, lack of social support, and in need of more intensive case management.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes your time.

The official opposition: Mrs. Elliott.

Mrs. Christine Elliott: I just have a couple of questions on completely different issues. One is a concern that has been expressed to me by primarily nursing care providers that the practice that's been adopted by CCACs of doing direct hires is a conflict of interest that is negatively affecting them. I was wondering if you could tell me where you have decided to do direct hires and explain the rationale for that, please.

Ms. Stacey Daub: I was hoping this question would come because I've heard the issue of conflict of interest, and I'm not quite sure what they mean by "conflict of interest." It would be helpful to have a direct conversation with the providers, which I have tomorrow and will ask what they think that actually means.

CCACs have hired, directly, care providers for as long as I know, and I've been in the business—we hire occupational therapists, physiotherapists, social workers, nurses, in-care coordinator roles. Many of us, for many years, have been hiring pharmacists, nurse practitioners. Where it has been a local CCAC choice, it has been about the needs of a population or a client and our partnership. So, for example, with palliative, it made more sense to have a nurse practitioner associated with our physicians and our care coordinators working with the community nurses rather than having nurse practitioners hired by 10 or 15 different organizations. It made more sense to have a centralized team. It was in the best interests if the clients and it was in the best interests of the team. In fact, Russell Goldman, who is our medical adviser from Mount Sinai, helped us to think through that, and so did patients.

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I think what's interesting is that on the ground, when I talk to nurse practitioners and front-line nurses, they don't seem to have an issue with it. They work it out. They have respective roles. Laurel made reference to the fact that they have unique yet complementary roles, and their roles are to work together. So I generally don't hear the issue at the front-line level; I hear it up at the organizational level. Again, without having a direct conversation, I couldn't guess why.

More recently, in the last year, we were actually directed by government to take on a new role. We were given a new role. I'll give you a couple of examples. One was nurse practitioners for palliative, and many of us had already been employing them for years. South West had them, I had them, and Central West had them. So that was nothing new, and it actually came as a blessing, because for our palliative clients, it was very helpful to bridge the gap sometimes when there wasn't primary care.

Mental health nursing was the second one. I myself wondered whether that might be a good role for the organization, so I consulted—even though government asked me to do it, I consulted with local partners. I phoned Mary Jo Haddad at the Hospital for Sick Children, I talked to CAMH and I talked to Dellcrest, and I talked to them about whether this was the right role. What they told me at the time is, "You're already in the schools, you already have a way in there, and you're going to be the first people to get care to kids who need mental health support, and we'll support you in terms of our supports and mental health training." In fact, in that particular situation, all 14 of us worked with the RNAO to get standardized training.

Where programs make sense—and those roles, too, never existed before. I can't imagine why there's a conflict, because they don't exist anywhere else; they're not competing with anybody else. In that particular circumstance, I know in my community it made local sense as a way to get the care as quickly as possible to the kids in the school.

So those are two examples, and I don't know whether Sandra wants to—

Ms. Sandra Coleman: Again, I think the important part is that we didn't submit a business case and ask for it to happen; we were asked to deliver on this new program. I think part of the thinking, in addition to that patient focus that Stacey mentioned, is just also that they are scarce resources. In all of South West, there are 11 mental health and addiction nurses. If you can imagine a little bit about our geography, we deal with 474 schools, so I think part of it was also from a practical reality in terms of that critical mass. If you attach them to individual school boards, they're then dispersed, and you don't have that consistent approach across either any individual LHIN area or potentially across the province, and so I think that is something about the CCAC infrastructure that makes it attractive for government to ask us to roll out new programs, because we can ensure consistency across our geography, but also we work quite closely as a team of 14 CCACs.

Mrs. Christine Elliott: The concern that I heard expressed to me was that when you are the organization that is responsible for awarding contracts based on best value and best service and then doing direct hires yourself—what I've heard from some providers is that the overall costs are higher because what you pay directly is greater than what is paid through the contracted providers. Have you noticed any difference in your bottom line by proceeding with direct hires in this way?

Ms. Sandra Coleman: I can only speak for South West. We have not done that economic evaluation. The programs are still pretty new, but it would be timely, at

some point over the next year or so, to do that—once the program development and partnership development and the outcomes in tracking measures start to come in—to be able to ask that question. I'm not aware that we pay more than anyone else. I'm not aware that that's the case. We set our compensation according to the collective agreements that we have in place.

Mrs. Christine Elliott: I think that probably would be a good exercise and analysis to go through, because we want to get the best value for taxpayers' dollars, of course.

Ms. Sandra Coleman: Absolutely. And I think, again, to look at the roles: The roles are very different from any of the roles being done by our contracted providers. The mental health and addiction nurses are focused on that consult with the children in the school who need immediate triaging and access to resources in order to ensure that there's either a transition—they've been in hospital, potentially, and are now wanting to return to school, or, in the case of mental health issues, there's a worry around crises that may be happening. So we may be the front face of the interaction with the teacher or the school, the principal for that child, but then the role is to involve all of the other partners. There has been significant partnership development with the other mental health providers to make sure that they are still being brought in in all of the appropriate cases. It is being thought of as an enhanced catcher's mitt to make sure that the people and providers are being involved the way—and that no one's falling through the cracks.

Mrs. Christine Elliott: Do I have time for one more?

The Chair (Mr. Ernie Hardeman): About two minutes left.

Mrs. Christine Elliott: Okay. My other question has to do with administration costs, and you've heard a lot about that. I think there's a difference of agreement about where care coordinators fall—whether they're considered to be part of the admin budget or a front-line service provider. I guess my question would be to Ms. Stroz in terms of the percentage of the time that you spend in the community meeting with people versus the other administrative responsibilities that you have.

Ms. Laurel Stroz: Actually, the team I worked on was looking at that and looking at how we maximize the time that we're spending doing client care versus the necessary administrative tasks that we do. As I indicated before, I worked with a very needy population, and I did my best to be on the ground at least three days a week. I was working in a small, tight-knit community, so I could see probably about 10 clients within that time. The other two days would be spent—I'd do a lot of educational work, and in conjunction with that I would be doing some administrative work. I don't know the exact percentage for you, but I could say that the majority of my work, due to the nature of my population, was hands-on work with clients.

The Chair (Mr. Ernie Hardeman): Thank you all for your presentations this afternoon. I know it may not seem that way to you, but two hours does seem to fly, doesn't it? Thank you very much for taking the time to come in and talk to us this afternoon.

DR. SAMIR SINHA

The Chair (Mr. Ernie Hardeman): Our next presentation is Mount Sinai Hospital's Samir Sinha, executive director—no, director of geriatrics. I'm in the wrong column here.

Good afternoon, and thank you very much for your attendance this afternoon. You will have 15 minutes in which to make your presentation. You can use any or all of that in your presentation. If there's any time left over, we will split it between the parties for questions or comments to your presentation. Your 15 minutes start right now.

Dr. Samir Sinha: Okay. Thank you very much, Chair, and thank you very much to the committee for giving me your time. I have a presentation here and I'm just going to try and get through it in about seven or eight minutes so that we do have time for questions as well.

On the first slide inside, I want to disclose the many hats that I do wear as a geriatrician. I'm here wearing many hats: one is that I'm the director of geriatrics at Mount Sinai, but when I was recruited back three and a half years ago from the United States, I was one of only 250 geriatricians in Ontario. I've taken a number of system leadership roles as well just so that I could help ensure the coordination of the care of my patients, given that I care for very frail, complex older patients across hospital, outpatient and home-based settings as well. In May 2012, I was appointed by the Minister of Health to lead the development of a provincial strategy around seniors.

Slides 3 and 4, in particular, speak to the reason why seniors have become a particular focus for the province: They number 14.6% of our population, they will double in numbers over the next 20 years, and they already are responsible for half of our current health and social care spending. Slide 4 just gives you an example that, again, they number 14.6% of our population yet they are responsible for 60% of our in-patient hospital days in Ontario.

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I've had the privilege of meeting with well over 10,000 Ontarians now to talk about the issues of seniors in particular, and slide 5 talks about some of the things that I heard through those consultations. For example, I think that we still are living within a system where we do little to empower older adults and caregivers with the information they need to navigate the system. We heard about that earlier in the conversations. We also don't require that any of our current or future health and social care professionals require training in the care of the elderly.

Another big issue that we have to address, if we're going to take our future challenges seriously: We still have very strong issues with silos between those who provide care—between hospitals, between primary care

and between our community care providers. That's a problem. We also talked earlier around the need for better capacity planning so we know what services we need to provide.

Slide 6 really just talks about the issue that—again, when you talk about the patients that I care for, those represent the 10%—the most complex individuals within our health care system. When you just look over the health care spending amongst those who are 65 and older, that 10% accounts for 60% of the health care spending, or $12 billion for 190,000 older adults on an annual basis.

The goal of the strategy was really thinking about how we address our dilemma—which is on page 7—really focusing on that we actually have a mismatch. I often am quoted as saying, "The patients have changed and our system hasn't." When we founded medicare in Ontario 50 years ago, the average age of a Canadian was 27 years of age. The average of an Ontarian today is 47 years of age, yet we have a system that was organized, as we heard before, for a younger population in particular. Our system is not currently matching the needs of its current and future users. Therefore, we need to address this. The majority of Ontarians told me that they plan to age in place.

I don't know if I'm allowed to ask the committee, but I asked this of over 10,000 Ontarians: How many of you in this room aspire to age in place and not end up in a long-term-care home? How many of you aspire to end up in a long-term-care home? One person; exactly. But the point is, the majority of you do not raise your hands because you would like to age in place, with your things—

Mr. Ernie Hardeman: I already live in a long-term-care home and I hope to live there forever.

Dr. Samir Sinha: There you go. Okay.

On page 8, you'll see my patient today, Mr. W, who is 104 years old as of a few days ago. He's supported through a house calls program, a home-based primary care provider. I provide his geriatric care in the home. He actually went to Mount Sinai Hospital. I've been out of the hospital all day today, but I can tell you that he was in the hospital at 9 o'clock this morning when he was having chest pains that weren't relieved at home. He was sent in by EMS, he was evaluated by our GEM nurse and he was actually just sent home two hours ago. How do I know that? Because we have everything integrated on our iPhones; we actually have things connected for those frail patients—again, another eHealth strategy that our hospital has implemented, connected with some of our community providers, including the CCAC. Anyway, it's how we've kept this 104-year-old back at home and not in the hospital, where he would have otherwise ended up today if we didn't have a good conversation occurring over email.

Page 9 really talks about the reason why the Ontario government decided to launch the development of the Seniors Strategy in particular. Ontarians told me that there were five key principles that were important to them: those of equity, quality, access, value and choice. Those are things that you have been talking about today.

Slide 10 really just shows you that, during the consultation process—I had six months to travel to every single LHIN in Ontario, work with the LHINs and consult with Ontarians. You can see that I communicated with over 5,000 older Ontarians, 2,500 front-line health and social care providers, and 1,000 caregivers. My report, which the next few slides talk about, is a 233-page report. I knew that many of you were wanting to focus on the issue of home and community care, so you do have the summary of the report but you also have the chapter on home and community care that raised the issues that I heard, but also some solid recommendations to move the system forward, which the Ontario Association of CCACs fully endorse, as well as many other providers. The report, by the way, has been downloaded by 25,000 people to date, and I'm glad to see that many of the political dialogues are no longer focusing on building more long-term-care beds but actually about strengthening home and community care.

Page 11 really focuses on the chapters that show how these recommendations shouldn't just focus around the health care system, but also, "How do we strengthen our communities to really help people age in place?"

Page 12 focuses on the fact that we had 33 non-health recommendations really focusing on those broader issues, and 133 health care recommendations, 90 of which I'm told are now being actively implemented by the Ministry of Health as they're implementing the work on the Seniors Strategy.

Page 13 really focuses on why we made the argument that more investments in home and community care are the way to go. It's not only more cost-effective, but it's actually what's in line with what Ontarians want.

Page 14 helps dispel some of the myths around what our investments in home and community care getting. The fact of the matter is, while there are people who are still waiting for long-term care in Ontario, you will see with the last point that the actual rate of placement of older adults—75 and better—into long-term care has actually decreased by 26% over the last three years, principally because we've invested almost half a billion more in home and community care over the last number of years.

Page 15 really focuses on what the government and myself in my role that continues are continuing to advance forward in looking at the role of home and community care, but also the other areas to support Ontarians to age in place: everything from strengthening primary care to focusing on health promotion and prevention, thinking about how we improve scopes of practice, and also looking at areas like community paramedicine, which was one of the latest announcements to move forward.

In terms of a moment or two on the LHINs, in terms of the next slide, page 16 and 17—really, are LHINs useful? Well, what I learned from my conversations and from the work that I've done in the UK and the United

States as well is that, again, no matter what jurisdiction I'm in or what area of health policy I study, health care is a local issue. The fact of the matter is, when you try and organize things centrally—I think that's important, that the government sets the tone and sets the agenda, but at the end of the day, the issues of the North East are very unique and different than the issues of Toronto Central. So I think LHSIA provided a better vehicle in 2006 to plan, integrate and fund local health care.

I think I'm one of the only people who can proudly say, in this room or in this province, that I've actually travelled to all 14 LHINs and I've dialogued with thousands of Ontarians about what was absolutely important to them. Again, despite their working limitations, I think the key—and what I realized—is that the LHINs have come of age over the last few years, in terms of they understand their local needs and influence and manage local change as best as possible, despite their limitations. I think we now have an opportunity, through this review, to say either we end the experiment or we actually remove their overall limitations, in my view, that can potentially support the necessary health care transformation that is needed over the next two years.

You will see two examples on slides 18 and 19 of things that I have been involved in. The Toronto Central LHIN is my local LHIN. One of the examples was that with almost half a million people in the GTA having limited English ability and requiring medical translation, you can see what the average cost for hospital translation services was: $1.70 to almost $8 a minute. Working through the Toronto Central LHIN, we were able to consolidate through one contract, not just with the hospitals but also now free of charge for local community providers. Access to these services at $1.44 per minute has not only saved dollars for all these providers, but it meant that people can actually get translation in their language of choice, which is absolutely important when making those decisions.

Another service that has been very personal to my heart was when the James Bay coastal chiefs and their elders invited me to go dialogue with the elders in those communities starting in February 2013. Those elders—where they don't have CCACs available in those areas to provide care, just the Red Cross—were saying to me, "We're not actually getting home care services because home care is not available in our community; therefore, our only choice when our care needs intrude is going to a long-term-care home in a community that we do not know, that's hundreds of miles away." Therefore, the North East LHIN has used the money that was coming back to them for unused home care services and actually has created a grow-your-own personal support worker program funded through the Red Cross, where we've actually had dozens of local people now signing up for these courses. The first folks were going to graduate in July. This has been an issue of economic productivity, creating jobs in these communities, but also providing care.

Slides 20 and 21 are my concluding slides, showing that when LHINs were formed in 2006, at that point the ministry chose to not enable greater control and integration opportunities for them, as we've seen in other areas where they've created regional health authorities in particular. The challenge is that their primary care services remain provincially administered. You've talked about how while CCACs in 2006 were merged to become coterminous with LHIN boundaries, their functions were not integrated with them. I think there were good reasons behind all of these decisions, but I think there are opportunities with a LHSIA review to focus on where things can go.

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Currently, the LHINs work with 2,000 service providers. I think that should be fewer. Right now, health care is becoming focused on the provision of services closer to the patient's home. We need to have greater integration of the services and service providers. We heard great stories today about how that's actually happening, but that's not always the reality, and we need to move forward in those areas.

I'm not sure who decided the LHIN boundaries, but the fact of the matter is, they also don't relate to public health and EMS services, which remained out of the tent and within the realm of municipalities.

In terms of where we should go, I think we need to give LHINs greater responsibilities, personally, for managing accountability for local primary, home and community care services in ways that enable better access, efficiency and quality.

I think we need to better define those responsibilities of health care service provider boards to support and enable ministry and LHIN priorities to make sure that they are actually working within the plan of what the ministry and the LHINs need them to do, not necessarily what they want to do.

I think we need to give LHINs greater flexibility to allocate funds and reduce administrative barriers to develop more integrated models of care that make sense locally.

My contact information is on the last slide.

I think I have left about five or six minutes for questions.

The Chair (Mr. Ernie Hardeman): All right. Thank you very much. We just have time for one caucus, so we will go to the official opposition. Do you have any questions?

Mrs. Jane McKenna: Thank you so much. Wonderful presentation. You zipped right through that. It was very well put together.

On page 17, you're saying here that, "I can say that despite their working limitations"—the LHINS, there. So what exactly are their limitations?

Dr. Samir Sinha: I think the challenge is that we've given LHINs the opportunity to start organizing and planning health care, but they have very little control. In my view, they're the magical flow-throughs of which funding decisions have been made by the Ministry of Health, but not necessarily saying if LHINs actually have a better way of doing something.

For example, on the James Bay coast, the fact of the matter is, home care services are just not available. In some of our rural communities, CCACs don't have reach into those areas. So the opportunity to actually give LHINs the opportunity to say, "How do we organize services in that context?" or if we need to actually get hospitals starting to say, "We need to actually get you putting that discharge summary"—Dr. Martino's comment; or at Mount Sinai Hospital, where we give discharge summaries—is great. That's great practice, but that's not the reality for most hospitals. Sometimes LHINs don't have the power to say, "Thou shalt do this," for example.

So I think the opportunity is to also say that CCACs have actually been saving hospitals lots of money, because they're getting our patients out of those hospitals sooner. But the key is that the hospital then doesn't give that money that they've saved over to the CCAC, for example, or to the LHINs, to say, "How do we shift that money to provide more home and community care?"

I think when you give LHINs more power, in my view—just like regional health authorities have had in other jurisdictions—sometimes that means you get rid of all the boards of all those local organizations. These are very political decisions to make. But sometimes we have to look at—in a thoughtful way, of course: How do we actually enable those local providers to really be accountable for their local health populations and how to provide that care?

Mrs. Jane McKenna: As MPPs who are sitting around this table, we have job descriptions of what they are, and we can't say to people, "Well, we've got limitations," or, "We can't do this. We can't do that." So sitting through this process for—I don't know how long we've been doing it now. But I guess I'm curious that I always think, if you're not part of the solution, you're part of the problem.

Dr. Samir Sinha: Absolutely.

Mrs. Jane McKenna: At what point, after eight years—I think it's eight years they've been around—do we finally get a job description, understand what everybody's doing instead of—there's just so much clouded area all the time. Even here today with the CCAC is, "This isn't my responsibility," and this and this and this. I guess where I struggled with all of this is: When can we make a case of who's doing what, what the job description is, so we can stop saying, "There are the limitations. They can't do this"? I'm curious when that happens, because eight years is a long time to be still saying—

The Chair (Mr. Ernie Hardeman): Okay. Your time is up. If you just want to give a quick answer.

Dr. Samir Sinha: Absolutely. So my patient who is 104 years old says, "I was waiting for this to actually occur a lot longer." This is a reason why this is a 233-page report. This is not fluff. This was taking all the answers we heard from different people within primary care, home, and community care, and starting to sketch out what our system needs to actually look like to move that forward.

That's why I presented 166 recommendations to the government. It built on Drummond. It built on Walker. But the key is that I haven't seen, sometimes, as much action as we needed.

I thank the government for recognizing this report and actually moving on it, but I'd like to see every single recommendation acted on, because I think it will address exactly what you're talking about.

Mrs. Jane McKenna: Thank you for your recommendations.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That which we haven't fully absorbed we will read at our leisure.

Dr. Samir Sinha: I appreciate it.

CENTRAL TORONTO COMMUNITY HEALTH CENTRES

The Chair (Mr. Ernie Hardeman): Our next presentation is the Central Toronto Community Health Centres: Angela Robertson. Thank you very much for coming in and sharing 15 minutes with us this afternoon. As with the previous delegation, you will have 15 minutes in which to make your presentation. You can use any or all of that time for your presentation. If there's any time left over, we'll have questions and comments from our caucus.

Ms. Angela Robertson: Thank you very much. As you've heard, my name is Angela Robertson. I'm the executive director of the Central Toronto Community Health Centres here in this city. I'm here today to speak on behalf of my centre and to inform, hopefully, your reflections and recommendations as you undertake this review process.

As you would have heard from other provincial presentations, community health centres are a community-based model of care that provide comprehensive primary care services in combination with health promotion and illness prevention services to people who typically face a range of barriers in accessing health care services. There are currently 75 CHCs in Ontario, 17 of which are in the Toronto Central LHIN. Our centre is located in the heart of the city, Queen and Bathurst, and provides services to four priority populations: folks who are homeless, folks who are living with mental health and substance use issues, youths at risk, and immigrants and refugees. I think it's significant to underscore that the majority of our clients are living with household incomes of under $20,000.

The goal of the LHINs, when they were envisioned in 2005, was to plan, coordinate, integrate, manage and fund care at the local level within defined geographic boundaries. This then was, and I think remains, a transformational agenda to create a patient-focused system and to move planning from the centre, as you've heard from Samir and others, of the ministry to the local; and from what was then the district health councils, which really lacked the resources and accountability levers to advance health system changes.

This was, and I think remains, a worthwhile vision. I'm here to comment on the strengths of the Toronto

Central LHIN and to offer some reflections on ways in which the LHINs can be improved for the next wave of transformation in the health care system. Specifically, I will speak to three areas:

—the LHINs' advancement of a heath equity agenda;

—the LHINs' role in local planning and collaboration across sectors with broad determinants of health framework and objectives; and

—the role and scope of the LHINs with respect to primary care.

I think I will echo some comments that you've also just heard earlier.

On the advancement of a health equity agenda, significantly, in 2005, when the province launched a series of consultations to inform the creation of the LHINs, I was a participant then as the executive director of a small community mental health support organization. At that time, as key stakeholders, we were asked to identify 10 priority health system opportunities. Many of the identified priorities dealt with a range of issues related to targeted populations, whether it be mental health, seniors, addictions. Others were broader and targeted opportunities talking about the system as a whole. But within the Toronto Central LHIN, one of the priorities defined by the community was the TC LHIN advancing action, planning and investments in a health equity agenda with a goal of improving access and health outcomes for marginalized populations.

This we felt was a significant focus in Toronto because health equity was identified as a priority, because as you know, Toronto is home to large immigrant, racialized and multilingual communities. We have high levels of low-income households concentrated in what are termed "priority neighbourhoods" across this city. As well, we have high levels of homelessness and individuals who are precariously housed, and the evidence clearly tells us that there's a gradient in health whereby people with lower income, education and who are faced with other social determinant challenges around exclusion have poorer health and poorer health outcomes.

I think with that it was important, from my work and from the work of others in the organization, that the TC LHIN's leadership in adopting health equity as a key enabler, embedded in its strategic plan and with defined priorities, was also a major strength. The LHINs' leadership on this has resulted in four priority actions to address health equity which I think are instructive for this review process and for LHINs system-wide.

1630

They engaged in a process around the importance of equity data collection at the point of care. One of the things that we know, from the work that you're doing here and work that's happening next door, is that what you count matters and that what matters should be counted. The LHIN has worked on the data process around equity in terms of capturing equity data.

The other piece that the LHIN identified as a concrete action around equity was equity indicators. You heard from Samir around the advancement of a language interpretation service. One of the key indicators there was ensuring that, to improve quality of care, patients and their families could understand the provider and the provider could understand the patient as one of the core principles about delivering quality care.

We have seen also that the LHIN has adopted a health equity assessment tool, which is really asking providers, before they undertake large system and/or program change, to look at: How will that program or system change impact those who are most marginalized in accessing care?

As well, we have seen the LHIN undertake work to advance the French Language Services Act by putting accountability measures in place for us as health service providers to have in terms of plans to enable language access for francophone patients and their families.

We have also seen the LHIN address barriers to known health care services. We have seen the LHIN take a leadership role in seeking to respond to gaps created in access for refugee care that were left by some of the cuts that were made recently to the Interim Federal Health Program, and I think that has been a significant LHIN leadership.

We have also seen the LHIN take a role in identifying and prioritizing work to support aboriginal youth, particularly aboriginal youth mental health programs, and we've also seen them undertake work around developing cultural competency for us as health service providers to provide more competent and responsive care and having done that in partnership with local organizations, specifically the Ontario Federation of Indian Friendship Centres.

Lastly, on the health equity agenda, we have also seen the LHINs adopt and really incorporate and advance an accountability lever by asking all health service providers, particularly hospitals and CHCs, to provide annual health equity plans whereby the LHINs can hold us accountable as providers for really responding to those who are most marginalized with access challenges.

I would say that the LHINs' leadership on equity speaks to the value, and its embedding of equity principles speak to the value, of building support structures that can be responsive to those who are most marginalized in accessing care, and here's an opportunity that can be leveraged across the system and across the province.

In terms of speaking to the role of the LHIN in local planning, I believe this is an area where the Toronto Central LHIN has excelled. It has used its strategic priority of addressing the needs of the 1% to 5% of highly complex patients with the greatest needs, requiring the most resources, and preventing and delaying serious illness and injury among those who are at greatest risk of declining health as a catalyst to convene local planning opportunities and collaboration with institutions and community-based providers. I am proud, as a CHC, which might be seen as a lowly community-based organization, that as a result of that effort, we now sit at planning tables with area hospitals, CCACs, family health teams, solo-practitioner physicians and social service

organizations seeking to support and improve navigation of the system for vulnerable and marginalized populations.

The LHINs' population health planning approach is responsive, appropriate and effective. The TC LHIN's strength in planning and collaboration has been keen in its awareness that health care support and intervention is only one strategy to create good health outcomes. Hence, as part of this broader collaborative planning strategy, the LHIN has sought to include in its planning other sectors like the city, United Way, Toronto Community Housing Corp. and the Toronto Transit Commission, just to name a few, with other community partners. This, I believe, ensures that the transformational system it seeks to build is linked and integrated into the broader social fabric and conditions which—we know that other parts of the system have significant contributing value to health outcomes, and the LHIN has seen those other places as key partners to bring to the table.

The LHIN has also created sector tables for hospitals and CHCs as a way to convene and ensure that proactively we can come to the table not just with the problems but also to talk through in terms of solutions.

Lastly, in terms of the role and scope of the LHINs with respect to primary care—and Samir indicated this in his presentation earlier—while as a CHC we are in favour of keeping the regional structure of the LHIN, we believe they should be given greater authority and responsibility for the planning and service delivery of the entire primary health care system. This includes family health teams. Currently, CHCs are the only type of primary care providers included in the LHINs' mandate. It is a challenge, I would suggest, for system planning and collaboration to have the family health teams being outside of this planning system when we know that the majority of individuals who access care are accessing care through these other venues and through these other opportunities. I respect that providers in the family health teams have negotiated contracts with the OMA; however, there is no reason why management of those contracts should not be under the LHINs' mandate.

Health links, I believe, are an example of bringing family health teams to the planning and care coordination table with the LHINs. However, they are not accountable to the LHINs. The risk here is the creation of fragmented primary care system and delivery models with sometimes possibly no alignment on strategic priorities, both from the government's perspective and from the LHINs' perspective. This, I believe, can only serve to undermine the building of an integrated health care system focused on keeping people well, not just treating people when they're ill.

As the evidence shows, early detection, treatment and intervention upstream create conditions for better health outcomes for patients and, in the long term, are more cost-effective for the health care system as a whole. Hence, an integration of the full scope of primary care under a single planning entity can make the LHIN a more responsive body, and I think the evidence proves that this would be worthwhile to pursue.

In conclusion, at Central Toronto we strongly believe that the TC LHIN and the LHINs in general have played a key role in building a more responsive health care system with tangible accountabilities, and we support their continued work as regionalized bodies in leading the planning, coordination, integration, management and funding of care at the local level across the province. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We'll have questions and comments from the third party: Ms. Forster.

Ms. Cindy Forster: Thank you for being here today. This sounds like a pretty positive report about the Toronto Central LHIN from your perspective, but you haven't used any of your time to share with us perhaps some of the challenges that you face as a community health centre here in the centre of Toronto.

Ms. Angela Robertson: I think the challenge that I would begin with is on the third point, around the integration in terms of family health teams within the primary care structure. I think one of the things that we know as community health centres is that we will not be able to serve all of the most marginalized community members who need care—and that is part of our mandate, to focus on those who face significant barriers and challenges. With family health teams not being under the accountability structure of the LHIN, then some of that shared responsibility is hard to lever in terms of the broader structure of primary health care for family health teams. The fact that that isn't present is a significant area for system improvement. The impact for us is that it means sometimes limited ability to plan across the primary health care stream, and that includes with family health teams as well.

Ms. Cindy Forster: Another area that you touched on but you didn't go into any detail on is around the issue of housing. We've heard about Home First for keeping seniors in their homes, but we haven't touched today on housing as being one of those determinants of health for people living on the street, for people living in shelters. Can you make any comments or have you been at any tables where those discussions have occurred, and is there any move to try and funnel some funding from a number of areas to make sure that there is more housing available for our constituents?

Ms. Angela Robertson: Yes, the housing conundrum is a challenge. It's a challenge for us given that one of our priority populations is individuals who are homeless and/or people who are precariously housed. What we have seen in this LHIN is some effort to do collaboration with local housing providers, both within the supportive housing sector in terms of mental health, particularly, the mental supportive housing sector, but then we've also seen the LHINs seeking opportunity to engage a Toronto housing company. Most recently, in the St. James Town, there was some work done around how to bring better coordination around all of the care for folks who are living in low-income support housing.

I would say that there needs to be a much more concerted effort on the part of LHINs across the board to drive advancing of a housing agenda, because I think without secure housing, without stable support and a stable base—we can invest a significant amount in the health care treatment end, but folks are not stabilized around their housing, so therefore it makes sustainability of that health where that intervention has occurred virtually, sometimes, impossible.

1640

The Chair (Mr. Ernie Hardeman): That does conclude the time. We thank you very much for your presentation, and I'm sure that the direction you were giving to somebody furthering the cause, they were listening and getting it done.

Ms. Angela Robertson: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation this afternoon.

That concludes the public presentations this afternoon.

COMMITTEE BUSINESS

The Chair (Mr. Ernie Hardeman): We're now onto the next item of business, which was the motion that was tabled. The person tabling it is not here.

Ms. Cindy Forster: Correct.

Interjection.

The Chair (Mr. Ernie Hardeman): That's what I said: It's her motion. The committee can do anything they like with the motion if it's called, but if the person that's not here doesn't call it, it doesn't get called. She has moved it.

Ms. Cindy Forster: She has to be here to—it's already tabled. It's already moved, right? Can we not debate it?

Interjection.

The Chair (Mr. Ernie Hardeman): Okay. I'm told by the Clerk that we can have the debate on it if the committee wishes, because she moved it at the last meeting. With that, the committee's got the motion. Direction from the committee? Yes, Ms. Forster.

Ms. Cindy Forster: Thank you very much. Ms. Gélinas apologizes for not being able to be here to actually debate her motion, but when we talked about this—I think it was two weeks ago—at that point, there was another motion, actually, from the PC caucus, which I think ended up getting defeated. In any event, the reason that France Gélinas tabled this motion was that the Auditor General, who's going to be asked, I believe, by the PC caucus at another committee to review the CCACs, has told Ms. Gélinas that, although they're prepared and interested in doing that work, we would never see a report before June 2015 because of the backlog of work that is before the Auditor General's office already. So that is the reason that France moved this recommendation.

In addition to that, the information that the Auditor General would provide in June 2015 or later would really be a value-for-money audit after the fact, whereas this particular motion is asking for more than just a value-for-money audit. It's asking for expert witnesses, including the CCAC leadership and staff and organizations that fall under the CCAC, to come and make presentations to us—health policy experts as well as patients and their families—in addition to reviewing administrative practices and compensation packages for this organization. Now, she did say that, if the committee members here wanted to defer her motion until after the Auditor General motion is dealt with at the other committee, she'd be happy to do that as well.

The Chair (Mr. Ernie Hardeman): First of all, in clarification, at the last meeting, there was no other motion. There was an amendment proposed to this motion that was ruled out of order—

Ms. Cindy Forster: Correct.

The Chair (Mr. Ernie Hardeman): —so it's nonexistent. I would point out that what we're dealing with today is not whether a member that's not here would consider it appropriate to delay it or to deal with it. If the committee wants to do that, then they have every right to do that, whatever you—

Ms. Cindy Forster: I understand that.

The Chair (Mr. Ernie Hardeman): —want to do with the committee. I'd just point that out. So somebody could make a motion to defer it until another date. A motion like that would be in order, if the committee wishes that, or the committee can also carry on the debate and then actually vote on the motion, if you so wish.

So, with that, further discussion?

Mrs. Christine Elliott: Thank you, Chair.

The Chair (Mr. Ernie Hardeman): Yes, Mrs. Elliott.

Mrs. Christine Elliott: Ms. Forster is quite correct: There is a substantive motion right now before public accounts asking for the Auditor General to conduct quite a comprehensive audit. I'm pleased to hear that Ms. Gélinas would be amenable to delaying the vote on this particular issue until it has been clarified with the Auditor General as to exactly what she intends to do. I would certainly be happy to move a motion that a vote on Ms. Gélinas's motion be delayed pending clarification of the Auditor General's intentions in public accounts.

The Chair (Mr. Ernie Hardeman): Yes, Ms. Jaczek.

Ms. Helena Jaczek: Yes, thank you, Chair. I would go along with a deferral motion. From our point of view, I think we're very interested in the contents and what Ms. Gélinas wants to achieve. I think the Auditor General's review will be hopefully very comprehensive and include some of these items, but we have actually, during our committee hearings to date as part of LHSIA, requested some of these components already. I think we will be able to at least make some commentary in relation to some of these pieces that form this motion as part of the LHIN review in any event. We will be concluding that within this calendar year, so we might be able to point in a certain direction. But in terms of this motion to defer, we will support that.

The Chair (Mr. Ernie Hardeman): Okay. I would just clarify for the committee: A motion to defer—as

soon as you make it, there is no further debate, and you cannot include reasons as to why the deferral or when you are deferring it to. It's strictly a matter of deferring, and it will be up to the mover of the motion or anyone else to bring it back at a subsequent meeting. We can't relate it to anything else that's happening elsewhere.

Further debate on the motion?

Interjection.

The Chair (Mr. Ernie Hardeman): Well, we haven't heard it. Did you make a motion to defer?

Mrs. Christine Elliott: Yes.

Ms. Helena Jaczek: Yes.

The Chair (Mr. Ernie Hardeman): Okay, we have a motion to defer. We have a seconder. No further debate. All those in favour of the deferral? The motion is deferred.

Ms. Cindy Forster: Chair?

The Chair (Mr. Ernie Hardeman): Yes?

Ms. Cindy Forster: One more issue, actually, flowing out of our committee hearings today: I'd like to have the committee approve a request for a copy of the market review study on compensation for the CCAC CEOs that we heard about today from the treasurer of the Ontario CCACs.

The Chair (Mr. Ernie Hardeman): Okay. Noted, and it will be asked for.

Yes, Ms. Jaczek?

Ms. Helena Jaczek: Yes, Chair. I'm wondering, in terms of our timetable going forward, when we will have an opportunity to look at the review of the Local Health System Integration Act, 2006, interim report, draft number 1. We have been provided with that table of contents and so on. Are we going to have specific time set aside for that discussion?

The Chair (Mr. Ernie Hardeman): Yes. As it relates to the next meetings on this, on March 24, we will have the Ontario Medical Association and the Toronto Central LHIN for 15 minutes, and report writing, so we will start then to review the information that we presently have.

Ms. Helena Jaczek: Thank you. That's good news.

One of the things I noticed in reviewing the interim report, draft number 1, is that Carrie has included the 15 recommendations from the LHINs themselves. I found it quite difficult to actually understand the rationale for some of their recommendations, and I'm just wondering if we might not want to have further testimony from them as to why and what exactly they mean.

The Chair (Mr. Ernie Hardeman): Well, if I could just finish—

Ms. Helena Jaczek: Yes.

The Chair (Mr. Ernie Hardeman): The next Monday, March 31, we meet with the Ontario Hospital Association, so even though we will be doing report writing at the end of the next meeting, that will be the appropriate time for you to suggest what more could be done, and if there are more people who you would want to hear from because of what has been done so far.

Ms. Helena Jaczek: Thank you, Chair.

The Chair (Mr. Ernie Hardeman): The first meeting of the report writing is not to exclude further public hearings. Anything else? Yes, Ms. Forster.

Ms. Cindy Forster: Just a question: Do we have social policy again tomorrow from 4 to 6, or not?

The Chair (Mr. Ernie Hardeman): We don't have anything to talk about tomorrow. Those of you who wish to come—if it's the majority of the committee, I'll come and sit here, but if there isn't a majority here then there's no sense in the Chair coming either. Ms. Elliott?

Mrs. Christine Elliott: Chair, with your indulgence, I'd like to introduce another motion, if I might.

The Chair (Mr. Ernie Hardeman): Yes. We have another motion.

Mrs. Christine Elliott: I move that the Standing Committee on Social Policy commit one day a week to consider Bill 135, Ryan's Law (Ensuring Asthma Friendly Schools), 2013. This review will commence on Tuesday, March 18, with one session of public hearings on Tuesday, March 25, followed by two sessions of clause-by-clause on April 1 and April 8.

The Chair (Mr. Ernie Hardeman): The motion is in order, except that the timing of the first meeting is difficult because, to have committee hearings on a bill, you have to have more than 18 hours to tell the public, "We're going to have the meeting." In fact, normally for the committee hearing to be tomorrow, the notice would have had to be given to committee members last Thursday. I just caution on the motion that it's going to be difficult to implement it in that time frame.

Far be it from me to suggest that hearing it is inappropriate, but the motion would work without actually setting that date. If the member would move the day to an acceptable date, it would make it a more acceptable motion.

Mrs. Christine Elliott: Yes. Perhaps, Chair, if I could amend it to include that the review will commence on Tuesday, March 25, followed by two sessions of clause-by-clause on April 1 and April 8.

The Chair (Mr. Ernie Hardeman): Very good. Thank you. Further discussion? The motion will be to commence the hearings on the 25th, which is a week tomorrow.

Ms. Helena Jaczek: Could we have a copy of the motion so we can review it in some detail?

The Chair (Mr. Ernie Hardeman): The copy is presently being made.

Ms. Cindy Forster: Can we take a brief recess while we're waiting for the copies?

The Chair (Mr. Ernie Hardeman): Recess requested. We'll have a 10-minute recess to get the motion printed.

The committee recessed from 1652 to 1701.

The Chair (Mr. Ernie Hardeman): I call the meeting back to order. The Clerk has passed out the printed motion. I just want to point out that there is a bit of a challenge with the motion. We have too many Tuesdays and not enough dates, and so if you would just cross out the first Tuesday, which says "Tuesday, March 18," and

then go on with the rest of it: "One session of public hearings on Tuesday, March 25, followed by two sessions of clause-by-clause on April 1 and April 8." So it's just that, out of the original resolution, they left the first Tuesday in and added the second Tuesday, when it's actually going to start.

Ms. Cindy Forster: So how will it read, Chair?

The Chair (Mr. Ernie Hardeman): It will read, "I move that the Standing Committee on Social Policy commit one day a week to consider Bill 135, Ryan's Law (Ensuring Asthma Friendly Schools), 2013. This review will commence on Tuesday, March 25, for one session of public hearings, followed by two sessions of clause-by-clause on April 1 and April 8." You have to take the Tuesday, the 25th, and put it where Tuesday, the 18th, was.

Is everybody clear on what it says? Okay. You've heard the motion; it's moved by Ms. Elliott. Any discussion? Yes, Ms. Forster.

Ms. Cindy Forster: First off, I would say that I don't think we'd probably need two sessions of clause-by-clause on this particular issue. I think it's a pretty narrow issue.

I'd also like to know what else is on our agenda, because we're still dealing with the chemo dilution report. It's not finished, and we've spent hours and hours and hours trying to get that done, so that needs to be completed.

We're dealing with the LHINs review, and we still have people who we need to hear from, and we haven't even started to get up and running with that report. So I'm hesitant to commit to three full days over the next three weeks on this issue until I know where we're going to actually be going, and how quickly the LHINs report is going to be ready for us to start working on.

The Chair (Mr. Ernie Hardeman): I think I can somewhat, as Chair, answer some of the questions. First of all, we have finished the chemotherapy report. It is presently at the printer, so that's finished.

The second item is the two days. If clause-by-clause is finished the first day, then we would have time to move something on that same day to put something in the next week. It doesn't mean that two days have to be used; it just means that there are two days available. In fairness, if there's a lot of discussion in clause-by-clause and in the two hours available you couldn't get it finished, then you would be stuck with not being able to finish it at all. So I think—

Ms. Cindy Forster: Then you could actually book another day.

The Chair (Mr. Ernie Hardeman): —in the process, this is just making sure that there's sufficient time.

Ms. Cindy Forster: So I would propose an amendment to this, Mr. Chair, that it be: "This review would commence on Tuesday, March 25, with one session of public hearings, followed by one session of clause-by-clause on April 1."

The Chair (Mr. Ernie Hardeman): If I could, just for clarification, to make sure it works, if it meets the needs of the committee: If you just said "with clause-by-clause on April 1," you wouldn't necessarily have to limit that it wouldn't be two days. It would just say it was one day. But if you say only one day, then you could get stuck with the fact that you couldn't get it finished at all, because you couldn't go and finish it the following week.

So I agree with the committee that it likely won't take more than—it would seem really strange if you could talk long enough on that size of a bill to need two days for clause-by-clause.

Ms. Cindy Forster: Well, I would say, then, "followed by clause-by-clause on April 1," and just leave it.

The Chair (Mr. Ernie Hardeman): Okay. Yes.

Yes?

Ms. Helena Jaczek: Thank you, Chair. I suppose my concern is more around the process of introducing motions like this. We do have a subcommittee that could consider these items. There is a process through the House leaders. So I think we're fine with going ahead on this one, but we seem to be going down a path of sort of ad hockery here. I would much prefer to have a clear path of what we want to consider over the course of the session—

The Chair (Mr. Ernie Hardeman): Again, as Chair, I agree with you. We should have a process, but as you know, we have nothing on for tomorrow, and if we don't do something now, we won't have anything on the following Tuesday.

I do have a list of the bills that are before the committee. Bill 104 is the Protection of Minors in Amateur Sports Act. Number 2 is Bill 135, the one that's being referred to now. Three is the Paved Shoulder Construction and Bicycling Act, Bill 137. Bill number 4 is Bill 142, Major William Halton Day Act. And Bill 166 is the Toronto Ranked Ballot Elections Act. These were all the committee—the only one of the list that's out of order based on the timing I have on my list is the protection of minors act.

Ms. Helena Jaczek: So further to that, Mr. Chair, could I suggest that we can vote and go ahead perhaps on this one, but could we have a subcommittee meeting or some sort of process where we can look at that list—

The Chair (Mr. Ernie Hardeman): I would point out to the committee and the subcommittee—and I've already spoken to the Clerk—that there's a bit of a challenge with what we're doing, based on the committee that's going to deal with this bill starting on the 25th—there's not necessarily the same members of the committee that's dealing with this one, because this next one is not necessarily a health bill that would bring the health people in. So—

Ms. Cindy Forster: No, it is a health bill.

Ms. Helena Jaczek: Well, this one is.

The Chair (Mr. Ernie Hardeman): Well, it is, but it could very well be that the education people would have a greater interest in it than on the health bill, because it's what they do at school and not how health is administered. So we should call a subcommittee to set up how we're going to do the hearings. The notification for that

subcommittee will go to the sitting members of the committee, and they can then refer it to the critics that are required.

Mr. Mike Colle: Mr. Chairman?

The Chair (Mr. Ernie Hardeman): Yes?

Mr. Mike Colle: Just in terms of this motion, it's sort of difficult to decide what we should be dealing with—I mean, all of a sudden. There could have been some indication that this was going to come—that would have been helpful—that there would have been a subcommittee meeting. I know there are people here for the ranked ballot bill who are anxious to see it go forward. So who decides what goes—can I move a motion that we consider the ranked ballot initiative in this time slot? That's where we get to. Everybody cherry-picks a bill, and we don't like to deny any bill going forward, but on the other hand, who decides what cherries get picked if you don't have a process?

If this committee's going to deal with things fairly, you need some kind of subcommittee that sits and looks at a calendar and doesn't do this last-minute thing—"Well, we've got a date. Let's throw in this bill"—because there are other bills that could easily go in the same slot. You know, who plays God here, or who plays cherry-picker? I'm not sure.

1710

The Chair (Mr. Ernie Hardeman): No, it's not about playing God, and where we are right now is that we have two Tuesdays open, and anyone had the ability to put forward a motion of what we should hear. This one, in fairness, is fairly close, because I think traditionally we go to the order that they came in, and in the order that they came in, this one would be number 2.

Mr. Mike Colle: What's number 1?

The Chair (Mr. Ernie Hardeman): Number 1 is the Protection of Minors in Amateur Sports Act.

Mr. Mike Colle: That's Jerry Ouellette's bill?

The Chair (Mr. Ernie Hardeman): Jerry Ouellette's. It's been—

Mr. Mike Colle: He's tried that for five years, so let's bring that forward. I'll move that.

Miss Monique Taylor: Chair? I had my hand up, Chair.

The Chair (Mr. Ernie Hardeman): No, that's not the motion we have on the floor. The motion—

Mr. Mike Colle: Well, notice of motion: I'm putting forward a motion—

The Chair (Mr. Ernie Hardeman): No, Mr. Colle. You can't move a motion when there's a motion on the floor.

Mr. Mike Colle: Yes, but my motion will pertain to this motion, because if you vote on this, then you omit my opportunity to put forward Jerry Ouellette's bill.

The Chair (Mr. Ernie Hardeman): No. You can amend a motion in any way you want, except you can't change—

Mr. Mike Colle: Okay. I want to—

The Chair (Mr. Ernie Hardeman): No, no. You can't change the intent of the original motion, and your amendment would be out of order because it would be a direct contradiction to this motion, and you can't have a motion like that on the floor.

Yes?

Miss Monique Taylor: Thank you, Chair. You know, today we've seen a lot of things happen out of process, and it's really not the way things are supposed to be done. Things are supposed to be done in a process. This has been happening for many years, as I'm told, historically in this House, and I just feel that this should go to subcommittee to be discussed at that point of when these bills are going to come forward, instead of it being brought out at the last minute where everybody is running and scrambling to find an answer.

I know that you're in support of this coming forward, Chair, but you're sitting in the chair right now, so your position is to rule, not to have a discussion or an opinion on this, in my belief—with all due respect, of course. I just really think that this should be going to subcommittee and letting them deal with it there, because now we're seeing, as you saw what happened this morning, everybody jumping up with their own ideas.

Mr. Mike Colle: Yes, I've got two. I want to move Jerry's, and the ranked ballot people are here, anxiously—

The Chair (Mr. Ernie Hardeman): Order. I would just point out that the process is quite clear. This is discussion, in fairness, that could have been held at a subcommittee, with the recommendation, with exactly the same thing. That didn't happen. But remember, every subcommittee meeting is held with one member of each party at the committee, and then its recommendation comes forward exactly like this. You would have had no further notice of this coming forward if it had gone through a subcommittee and the subcommittee had said it was going to come here.

Mr. Mike Colle: No, but generally speaking, you get notice of a subcommittee meeting so you have time, and then you find out what's the subcommittee agenda. We are not given any agenda here, so that is not normal. I'm sorry, Mr. Chairman.

The Chair (Mr. Ernie Hardeman): It may or may not be. Right now, there is a motion on the floor to move forward with this bill that goes for a vote.

Mr. Bas Balkissoon: Take the vote.

The Chair (Mr. Ernie Hardeman): Okay.

Interjection.

The Chair (Mr. Ernie Hardeman): First we have an amendment to the motion. Ms. Forster moved that the motion be amended by striking out "and April 8."

Miss Monique Taylor: But I would like an amendment, Mr. Chair, that we move this to subcommittee.

The Chair (Mr. Ernie Hardeman): No. That's not an amendment.

Mr. Mike Colle: Sure. It's in order.

Mr. Bas Balkissoon: Sure, it is.

The Chair (Mr. Ernie Hardeman): You have to deal with the amendment on the floor. Ms. Forster made an amendment to move that the motion be amended by

striking out "and April 8," and that's the amendment that's on the floor right now—not the motion; the amendment to the motion.

Ms. Cindy Forster: I'll withdraw my amendment.

The Chair (Mr. Ernie Hardeman): Okay, so now it's withdrawn. Now what's on the floor is: "The Standing Committee on Social Policy commit one day a week to consider Bill 135, Ryan's Law (Ensuring Asthma Friendly Schools), 2013. This review will commence on Tuesday, March 25, with one session of public hearings, followed by two sessions of clause-by-clause on April 1 and April 8."

That's the motion that's now on the floor. Further discussion on the motion?

Mr. Mike Colle: I have an amendment.

The Chair (Mr. Ernie Hardeman): An amendment to the motion?

Mr. Mike Colle: Yes. I move that the Standing Committee on Social Policy's subcommittee meet to consider—

The Chair (Mr. Ernie Hardeman): That's not an amendment. That's not an amendment to the motion. You can take this motion and you can table it, refer it, anything you like, but if you're going to amend the motion, you can't change the motion itself. You can move it to a committee. You can table it. You can defer a decision on it and send it to the subcommittee, but you can't change the motion.

Mr. Mike Colle: Okay. Then I move that it go to subcommittee.

The Chair (Mr. Ernie Hardeman): Further debate on that?

Interjection.

The Chair (Mr. Ernie Hardeman): I think the only proper way to do it is to vote on the motion. You either vote and agree with this or you agree for the subcommittee to look at what should be heard.

Ms. Cindy Forster: Then I'll call for a 20-minute recess.

The Chair (Mr. Ernie Hardeman): A 20-minute recess.

The committee recessed from 1716 to 1736.

The Chair (Mr. Ernie Hardeman): Committee, come back to order. The motion on the floor is, "I move that the Standing Committee on Social Policy commit one day a week to consider Bill 135, Ryan's Law (Ensuring Asthma Friendly Schools), 2013. This review will commence on Tuesday, March 25, with one session of public hearings, followed by two sessions of clause-by-clause on April 1 and April 8."

You've heard the motion. All those in favour?

Mrs. Christine Elliott: Recorded vote, please, Chair.

Ayes

Elliott, McKenna.

Nays

Balkissoon, Colle, Dhillon, Forster, Jaczek, Taylor.

The Chair (Mr. Ernie Hardeman): The motion's lost.

Miss Monique Taylor: Chair?

The Chair (Mr. Ernie Hardeman): Yes?

Miss Monique Taylor: I move a motion that the Chair of the subcommittee on social policy call a subcommittee meeting to discuss how to proceed with Bill 135. And if I may speak to that?

The Chair (Mr. Ernie Hardeman): It's a motion, and you're allowed to speak to it—

Miss Monique Taylor: Thank you, Chair.

The Chair (Mr. Ernie Hardeman): —ad nauseam.

Miss Monique Taylor: The reason for us wanting it to go back to subcommittee is because we believe it's a very important issue, something that needs to be dealt with. We think that stakeholders need to have the proper, appropriate time to be notified, to have time to prepare to come to the committee to present their case. We want to support this, but we think that it needs to follow through the process to make sure that stakeholders do have enough time to be able to attend.

The Chair (Mr. Ernie Hardeman): Thank you. Any further debate? Ms. Jaczek and then Mr. Colle.

Ms. Helena Jaczek: Thank you, Chair. Certainly, I'm going to be supporting the NDP motion. Not only is this particular issue very important, but all the bills that are before this committee are important. To start picking and choosing, putting one ahead of the other, whether it's chronologically, when it was referred to us, or by any other type of criteria that you might judge—the order of this, I think, is something that should be very much fleshed out. But certainly, in terms of this motion, I'm going to be supporting it.

Mr. Ernie Hardeman: Mr. Colle.

Mr. Mike Colle: It is hard to, as I said before, decide which bill all of a sudden is on the agenda—and this is a very worthwhile bill that most of us would probably support and go ahead. It's not that. The point is that you can't throw these bills before us at the last minute without due process, without any kind of discussion, and then say to people, "Well, listen, we're doing this bill."

I think what we need to do is consider this bill at subcommittee, where it should have gone in the first place, and also consider the other bills that are before us so that we can decide and map out the calendar to see where we're going. If this is first, I'm okay with that, and it could go with that. But I just want to make sure that we have some kind of order and plan that gives due process to this bill, Jerry Ouellette's bill—what number is Jerry Ouellette's bill?

The Chair (Mr. Ernie Hardeman): Bill 104.

Mr. Mike Colle: —Bill 104, for instance, and Bill 166. I would like to ensure that, at subcommittee, we put some kind of plan together over the next number of weeks to see what we want to deal with in an orderly

fashion. This bill, along with the other ones, could be given some kind of calendar. It's basically a calendar motion, really, that will enable us to look at this in a reasonable way.

The Chair (Mr. Ernie Hardeman): Okay. Further discussion? We've just finished writing the motion? Yes, further discussion, Ms. Forster?

Ms. Cindy Forster: Yes, I just want to get on the record. I think Bill 135 is a very important bill—I mean, there's probably nothing as important as children's health. But there is a process, and I've been in other committees where this has happened. It doesn't give the people who are on the committee the opportunity to even go back and talk to your caucus about, "Well, what bills does my caucus have sitting in the loop here, and how long have they been there?" I think when they come up at the last minute like this, it really puts all of us at a disadvantage, including the people who we may be representing around the bill.

I think it will give more time and more thought to when hearings will be scheduled, and more opportunity for parents who may want to come and present to have some advance notice as well. But we are supportive of dealing with this bill as expeditiously as possible.

The Chair (Mr. Ernie Hardeman): Okay. Further discussion?

Ms. Helena Jaczek: Yes. I'm wondering if Miss Taylor would consider a friendly amendment, that the subcommittee meet to discuss all the bills that are before the committee, have that discussion and try to look at some orderly fashion of hearing them.

Miss Monique Taylor: I believe that the subcommittee has the right to speak to all bills that are before them, does it not?

Mr. Mike Colle: But that's why you have to amend it. If not, you can only speak to this.

Ms. Helena Jaczek: You've made it very specific, I think, in your motion—

Mr. Bas Balkissoon: So we're asking you to broaden it.

The Chair (Mr. Ernie Hardeman): You can do it either way, but the subcommittee always has the power to deal with all the bills. We don't need a resolution to do that. If the resolution is to move this bill forward, then the appropriate one is the resolution as it's written. But your amendment is in order, if you wish to make it.

Ms. Helena Jaczek: Would you have any objection to making it, that we consider all of them?

Mr. Bas Balkissoon: Put the amendment forward.

Ms. Helena Jaczek: I'll move that amendment, then.

The Chair (Mr. Ernie Hardeman): Okay. The amendment is to add—

Ms. Helena Jaczek: All the bills that—

Mr. Bas Balkissoon: Consider all the bills that are in front of us and come back with a time schedule.

Mrs. Jane McKenna: Isn't that what the subcommittee does anyway?

Mr. Mike Colle: But it hasn't done it.

Interjection.

Mr. Mike Colle: I know, but it hasn't been called because this motion's on the table, so you usurped the subcommittee. You should've called a subcommittee. We could've dealt with it in the subcommittee and brought the bill forward. That's all I'm saying.

The Chair (Mr. Ernie Hardeman): Who should've called a subcommittee?

Mr. Mike Colle: The Chairman should've called a subcommittee meeting.

The Chair (Mr. Ernie Hardeman): Yes, except the Chairman was doing something else in this committee. There was no reason for anything to come forward. Any member of the committee has a right to put forward a resolution to deal with the future business of the committee.

I want to point out that, when you go to subcommittee, they can make all kinds of decisions to bring back to the committee for the committee to decide. This is the ultimate place where it's decided, at full committee, so there is nothing inappropriate about someone putting forward a motion to deal with future business for meetings that we don't have anything scheduled for. If we go a long time with this one, all the time that's going to be spent with this one is going to be gone, because we have nothing in front of the committee. I'd just point that out.

Mr. Mike Colle: No, but we have the other bills before the committee.

The Chair (Mr. Ernie Hardeman): No, none of them are before the committee until somebody is willing to accept that.

Mr. Mike Colle: That's what I said. So the question is, who decides what bill should come before the committee?

The Chair (Mr. Ernie Hardeman): This committee, and that's what we're doing right now.

Mr. Mike Colle: But you wouldn't let me move the motion to say that we should be considering another bill.

The Chair (Mr. Ernie Hardeman): No, because the motion was before the committee—what you wanted to hear. That's the Chair's ruling, Mr. Colle, and you can't change it.

Okay. Now, you can change this motion. Is there an amendment to this motion?

Ms. Cindy Forster: I just want to ask a question of the Clerk. Does subcommittee not have the right as a subcommittee to make recommendations to bring forward to the committee about the bills that are sitting before them?

The Chair (Mr. Ernie Hardeman): Yes.

The Clerk of the Committee (Ms. Valerie Quioc Lim): Yes.

Ms. Cindy Forster: Okay.

Mr. Mike Colle: That's what it usually does.

The Clerk of the Committee (Ms. Valerie Quioc Lim): That's what it usually does.

Mr. Mike Colle: But not in this committee. It's the—

Mr. Bas Balkissoon: But their motion is to a specific bill, and we would like it to be—

The Chair (Mr. Ernie Hardeman): Is there any amendment to the motion on the floor?

Interjections.

The Chair (Mr. Ernie Hardeman): Order. You have a motion on the floor. Is there any further discussion or amendment?

Ms. Helena Jaczek: Yes. I'd like to amend the motion of Miss Taylor to say that the subcommittee will consider all bills before the committee, not simply Bill 135.

The Chair (Mr. Ernie Hardeman): Okay. If you could provide the right wording—

Interjection.

The Chair (Mr. Ernie Hardeman): Mr. Colle, order. If you could word it in a way the Clerk can record it so we can vote on the amendment.

Ms. Helena Jaczek: Could I have a copy of Miss Taylor's motion, then, please?

Ms. Cindy Forster: So when's the meeting? When's the subcommittee meeting, Chair?

The Chair (Mr. Ernie Hardeman): As soon as we can call it.

I would just point out that, even with the original motion, it had to have a subcommittee meeting to set the process in place to make it happen. So it wasn't eliminating a subcommittee meeting, it was just to get things moving. And I commend one of the parties for putting something forward. No one else did.

Mr. Mike Colle: No, but this motion neutered the subcommittee by basically instructing the subcommittee to do specifics.

Miss Monique Taylor: No.

Ms. Cindy Forster: No.

The Chair (Mr. Ernie Hardeman): No, it doesn't.

Mr. Mike Colle: Yes, it does.

The Chair (Mr. Ernie Hardeman): No, it doesn't.

Mr. Mike Colle: It does neuter the subcommittee.

The Chair (Mr. Ernie Hardeman): The subcommittee could come back with a recommendation that says that Bill 135 should be dealt with after everything else on the list has been done. That's what the motion does.

Mr. Mike Colle: No, but then you gave the subcommittee a pretty specific directive. That's what I'm saying. You're putting the subcommittee in a very awkward situation. That's all I'm saying.

So when would the subcommittee meet? Then we could deal with this next week or—

Interjection.

Mr. Mike Colle: When would the subcommittee meet, and when would we deal with the bill, then?

The Chair (Mr. Ernie Hardeman): The resolution says that the Chair should call a subcommittee meeting, and that will be done as quickly as we can get a subcommittee together.

Mr. Mike Colle: As long as we respect the subcommittee, Mr. Chair. That's all I'm asking for: respect.

The Chair (Mr. Ernie Hardeman): Oh, there's nothing but respect for the subcommittee.

I just want to point out that the difference between the subcommittee and the whole thing is that the subcommittee is split evenly between the parties and the whole committee gives the advantage to the governing side.

Mr. Mike Colle: But not in this case.

The Chair (Mr. Ernie Hardeman): Yes, it is.

Mr. Mike Colle: We're outnumbered, though.

The Chair (Mr. Ernie Hardeman): No, you're not.

Ms. Helena Jaczek: No, it's equal. And the Chair votes with the—

The Chair (Mr. Ernie Hardeman): I vote with the status quo.

Mr. Mike Colle: There's four to—

The Chair (Mr. Ernie Hardeman): On the subcommittee?

Mr. Mike Colle: No, no, on this committee. Who are the sitting members?

The Chair (Mr. Ernie Hardeman): Four and four.

Mr. Mike Colle: Okay.

The Chair (Mr. Ernie Hardeman): We'll return in a couple of minutes. Committee is recessed.

The committee recessed from 1749 to 1752.

The Chair (Mr. Ernie Hardeman): Okay, we'll come back to order. Everyone has a copy of the motion on the floor, and we have someone who wants to make an amendment to it.

Ms. Helena Jaczek: Yes, Chair. If I could amend the motion to say: "I move that the Chair of the subcommittee of social policy call a subcommittee meeting to discuss how to proceed with Bill 135 and all the other bills before the committee."

The Chair (Mr. Ernie Hardeman): You've heard the amendment. Any objection or any discussion on the amendment? If not, all those in favour of the amendment? All opposed? The amendment's carried.

Now the motion will be: "I move that the Chair of the subcommittee of social policy call a subcommittee meeting to discuss how to proceed with Bill 135 and all the other bills before the committee."

Any discussion on the motion, as amended? No further discussion? All those in favour? All those opposed? The motion is carried, as amended.

Mrs. Jane McKenna: Hit that gavel, will you? Come on.

Interjection.

The Chair (Mr. Ernie Hardeman): I guess we didn't get a chance.

The committee's adjourned.

The committee adjourned at 1753.

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ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40e législature

Official Report of Debates (Hansard)

Monday 24 March 2014

Journal des débats (Hansard)

Lundi 24 mars 2014

Standing Committee on Social Policy

Comité permanent de la politique sociale

Local Health System Integration Act review

Étude de la Loi sur l'intégration du système de santé local

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

Président : Ernie Hardeman
Greffière : Valerie Quioc Lim

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Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
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Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

Monday 24 March 2014

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Lundi 24 mars 2014

The committee met at 1402 in committee room 1.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

ONTARIO MEDICAL ASSOCIATION

The Vice-Chair (Mr. Ted Chudleigh): I call the meeting to order. We're here to resume the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act.

Today, we have the honour of having the Ontario Medical Association with us. If you would take the chair, you have 30 minutes for your presentation and then we get to ask questions for an hour and a half—goodness gracious; that has to be some kind of a record. We appreciate your attendance and we look forward to your expertise in this area. If you could each name yourselves for the purposes of Hansard, that would be very helpful to the people recording these proceedings.

Dr. Scott Wooder: Thank you, Mr. Chair. Scott Wooder.

Mr. Richard Rodrigue: Hello. Richard Rodrigue.

Mr. Peter Brown: Peter Brown.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. Please proceed, sir.

Dr. Scott Wooder: Thank you, Chair, and members of the committee. We appreciate the opportunity to be here today. My name is Scott Wooder. I'm the president of the Ontario Medical Association and a family physician from Stoney Creek. With me today is Peter Brown, a senior policy analyst from our health policy department, and Richard Rodrigue, senior regional manager, northern region, from our engagement program delivery department.

The Ontario Medical Association represents the political, clinical and economic interests of the province's medical profession. We represent about 30,000 physicians. We also represent medical students, retired physicians and residents.

The OMA is committed to ensuring that physicians are at the forefront of building a stronger, higher-quality and sustainable health care system for patients. We believe that Ontario needs to focus its efforts on building a patient-centred health care system that enables integration between providers and creates a collaborative network of care centred on the patient. The OMA believes that these integrated relationships need to look different in each community, as they will reflect the unique mix of patients, physicians, resources, other health care providers, and geography. My comments today will focus on how the LHINs can better facilitate integration with physicians. I'll offer comments about improvements that the LHINs could make in executing their current responsibilities and highlight examples of successes as evidence of how the current LHIN authority is sufficient to achieve our shared goals.

In 2006, the government of Ontario passed the Local Health System Integration Act and divided the province into 14 LHINs. The government chose integration as the backbone of its regionalization strategy, and the OMA believes that focus serves us well. It creates a shared goal—integration of services—but allows for flexibility in how that is achieved to meet local needs.

A number of services, including hospitals, CCACs, community support services, long-term care, mental health and addiction services and community health centres, were placed under direct control for LHIN planning and funding. However, the government rightly retained responsibility for other things, including major capital projects, physicians, ambulance services, laboratories, provincial drug programs, provincial networks and programs, independent health facilities and public health. We understand from following the proceedings of this committee that some groups, including the LHINs themselves, are interested in expanding the LHINs' authority. The discussions about primary care are of particular interest to the Ontario Medical Association, and I'd like to talk about it for a moment.

As I'm sure you know, physicians differ from the list of providers that are under full LHIN control by the fact that our practices are not funded by the government. Medical practices are self-funded by the physicians who run them. We run small businesses. Although the government remunerates physicians for the services we provide, they don't fund any infrastructure costs or provide costs for staffing and supplies. In addition, physicians have no benefits, WSIB or pensions. It's difficult to imagine how LHINs could assume control of self-funded services without fundamental changes to the system.

It's not clear to me that the people who have proposed the idea of moving primary care under LHIN control have a full understanding of either the current system or how extensive and disruptive the suggested changes would be.

Although the OMA has serious concerns about the proposal for LHINs to control the delivery of primary care, we strongly support efforts to better integrate our system and believe that family physicians need to be at the table.

I'm going to change focus now and talk about system change and how to best engage physicians.

I'll start by saying that physicians want to improve patient care, but we've got limited infrastructure, time and capacity within our practices. That means we need to see that any proposed system will result in real improvements to patient care. Changes also need to be practical—talking with physicians early in the process will help LHINs make sure they pursue relevant and achievable aims.

Successful LHINs have found ways to engage physicians in timely and transparent ways to achieve meaningful results. I'm going to talk now about some of the things that the OMA is doing to support LHIN engagement with physicians.

In 2007, the OMA established a regional engagement service to facilitate physician relationships with the LHINs and other regional system partners. We have seven regional managers based across the province. Mr. Rodrigue is one of them. The regional managers serve as local OMA points of contact for physicians and work with local health care stakeholders to ensure physicians are informed, involved and engaged in influencing local health care.

The OMA has also invested in the development of primary care councils. In some LHINs, these are known as primary care networks. These formal networks of physicians, other health care providers and health care institutions within a given community meet regularly with LHINs and other system partners to discuss and seek solutions to local services. As a new initiative, these councils are active in some areas and in development in others. Over time, it's anticipated that these councils will be a key contributor to improved physician engagement, service integration and delivery at the community level.

The OMA knows that clinical expertise is even more powerful when coupled with system knowledge and leadership skills, so in 2010 we established the Physician Leadership Development Program in collaboration with the Canadian Medical Association. Physician leaders graduating from this program are applying their skills at all levels of the system, including the LHINs.

I'd like to talk a little bit about some of the elements of successful collaboration from the physician perspective. One recent example of effective and meaningful integration is the Ontario health links program. Health links are an example of how greater collaboration between existing local health care providers can occur without changing the existing responsibilities of the LHINs or any other system partner. The program is based on the notion that a fully integrated health and community care sector improves the ability to provide more appropriate and less costly patient care to Ontario's seniors and those with complex conditions. Through a partnership model, key providers are brought together within a health link. This is achieved by articulating a clear vision, demonstrating value to the participants and empowering their participation in the development of care pathways and practice-based resources. This ultimately enhances the capacity to provide high-quality, effective and efficient patient care.

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Evidence shows that physician commitment is critical for sustainable change. Local clinical leaders have an integral role to play in local planning and implementation because they support individual clinicians in fulfilling their accountabilities. They do this by enabling communication, creating awareness and facilitating the training and education that prepares their colleagues for change.

However, LHINs must be cautious about relying too heavily on a cadre of like-minded clinical leaders. Real partnership requires that front-line physicians feel they have a voice in the system, too. Physicians expect a partnership relationship with the LHINs and want to contribute to their success. Building a partnership necessitates engaging physicians and other health care providers from the outset. This helps to instill a sense of ownership over health care improvements and reduces the resistance to change.

I'd like to tell you a little bit about my personal experiences in physician engagement so that you will understand my background and interest in this matter. I've been an elected member of the OMA board, a director since 2003. Before that, I was the lead physician in primary care reform. I've been on three negotiations committees, twice as chair, and I've chaired the OMA committee responsible for implementing Ministry of Health and Long-Term Care and OMA agreements.

Whenever I've gone to a physician group and told them what we were planning to do, I have received serious pushback from our members. This occurs even when the suggested changes have merit. The process that has worked is asking physicians what challenges they face in providing good-quality care for their patients, asking them for suggested solutions and then bringing back a product that actually reflects their input. Physicians want to be engaged in a real, meaningful way. We need to learn from our experiences and build upon them to move the province forward.

In closing, the LHINs have a leadership role in integrating services and aligning priorities tailored to regional and community needs. They need to work with Ontario's doctors to make it work.

Thank you, Mr. Chair.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. You had 30 minutes; is there any other—that's it?

Dr. Scott Wooder: No, I didn't think we would use the entire 30 minutes.

The Vice-Chair (Mr. Ted Chudleigh): That's fine. Thank you. We will now move to the third party for questioning. Each party will have 30 minutes of

questions, and you can take it as a block or you can go into rotation; that's up to you. Yes, Ms. Gélinas.

M^me^ France Gélinas: Let's get started. Good afternoon and thank you so much for coming and participating in the review of the LHINs. My first question comes from page 3—I don't know if your pages are lined up the same as mine—where you make the comment: "However, LHINs must be cautious about relying too heavily on a small cadre of like-minded clinical leaders." What did you mean by that?

Dr. Scott Wooder: Well, there are 30,000 practising physicians in the province in the 14 LHINs, so there are several thousand physicians in each LHIN. Our concern is that if a LHIN engages with a very small group of physicians, hires them for their expertise—we're glad they're doing that; we think they should, but if they only get input from a couple of dozen physicians, then they may not get a clear picture of what's actually happening within the LHIN. We'd ask them to consult more broadly than just within a small group of people they've engaged.

M^me^ France Gélinas: Can you give me an example where a LHIN might have done this, where they consulted mainly with like-minded clinical leaders?

Dr. Scott Wooder: Sure. We did a survey of our members in January of this year. We asked them a series of questions about LHIN engagement and we kept responses from over 1,000 members. Eighty-five percent of the respondents did not feel that the LHIN had been effective in creating early and meaningful involvement of physicians in planning and priority-setting; 71% indicated that if they wished to provide input to the LHINs, they would not know how to do that; and two-thirds indicated a willingness and eagerness to provide that input into strategic planning. We have physicians who don't think that they have been engaged and don't know how to get engaged but wish that they could get engaged.

M^me^ France Gélinas: Rather interesting.

We've talked a bit about engagement and how it doesn't seem to work too good. If you could decide how it should be done, except from what you've shared with us, how do you see it rolling out to physicians in my riding that could be the solo physician in town or a very small group practice? Most of them bill OHIP and don't get paid to participate in engagement meetings or anything like that.

Dr. Scott Wooder: First of all, you raised a great local issue in Sudbury and the north, where there's much more isolation. But in general, the process we see centres around the primary care councils that we've put in place. In those councils, which we've supported financially, there are physicians, other providers, institutions, hospitals and CCACs. The groups come together, try to solve problems and, most importantly, of course, come up with solutions that help our patients.

We would see the need to reach out to physicians. In some LHINs, physicians get an invitation to attend the meeting, which is great but doesn't always fit into physicians' work schedules. Physicians have a very difficult time meeting through the day. They're sometimes available very early in the morning or long after the workday has been completed. But we'd like a much more proactive engagement of those physicians—seeking their views. We think that other physicians are the key people to do that.

M^me^ France Gélinas: So if I understand, what you're saying is that the physician that is the primary care physician lead at the LHIN would reach out to his or her peers within the medical society at a time that is accessible to physicians billing OHIP? Is this the idea?

Dr. Scott Wooder: Yes. The primary care leads that you've talked about—I don't want to misrepresent it and say it has been a total failure. I know many of them. They're fantastic individuals. I think they need to be supported. We'd be happy to provide some infrastructure so they can talk to our members, their colleagues, and get these ideas to bring back to the LHIN. Rather than the LHIN provide the vision and goals, it should be asking the providers.

M^me^ France Gélinas: We know where sometimes the primary care physician leads did not work out so good. Can you give me an example where it did work out good, and what was the difference?

Dr. Scott Wooder: Sure. With the Chair's permission, I wonder if Mr. Rodrigue could speak to that.

Mr. Richard Rodrigue: Thank you. There have been some—I take the South West LHIN as an example—where they were set up early and certainly did a lot of key work in ensuring that the process was owned by the participants of the primary care network and that they had some good broad-base interactions with physicians and grassroots engagement, which they feel is very critical to their ongoing success.

I think about the North Simcoe Muskoka LHIN and their primary care network there. They've been effective in quickly getting the message out to the community in regard to rapid-response nursing initiatives, which has benefited the reduction of ER readmits.

Those are a couple of the examples that I'm aware of. Some of my colleagues are still working with the primary care networks to support them and to help them engage with the physicians in a broad-base fashion.

I personally work with the North East LHIN, with Dr. Al McLean and with the LHIN staff, to help support the primary care advisory council there and look at opportunities for engaging at a broader system level with physicians.

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Dr. Scott Wooder: Just if I might, Mr. Chair, I'm not trying to make the point that the LHINs have been failures in engaging the primary care sector at all. What I'm saying is, they have not yet been completely successful. If they are allowed to continue with their work, and if they come to us for expertise that we have engaging physicians, I think they can be successful. The real point we're trying to make here is that if the LHINs take over all the planning related to primary care, that initiative that's just in its formative stage will come to a screeching halt.

M^me^ France Gélinas: All right. Those are rather powerful words. Let me peel the onion on that. There are talks about the LHINs' mandate being—actually, primary care planning was always in the mandate of the LHINs. You're just saying that it's coming about now?

Dr. Scott Wooder: Our understanding, from following these proceedings, is that the LHINs are asking for an expanded role in planning primary care. Rather than that, we are suggesting a partnership between primary care providers, primary care physicians and the LHINs. We think that that partnership is the best way to help create an integrated system that will allow us to provide the best possible care for our patients.

M^me^ France Gélinas: When you say "us," do you mean the OMA, or do you mean the local membership?

Dr. Scott Wooder: I mean us as a province. I mean the providers, the payers, society at large.

M^me^ France Gélinas: So let's say the LHINs are given the go-ahead to start to plan for primary care in a more robust way than they have been doing in the past. You see this planning moving forward as a partnership with the physicians who practise within their catchment area. Is that it?

Dr. Scott Wooder: No; I see the current situation as one that should be a partnership between LHINs and providers, including physicians. I see it as a partnership that's an evolution that needs to improve, but if the relationship changes and the LHINs are given more power over primary care, I see that as an obstacle in that partnership.

M^me^ France Gélinas: I'm trying really hard to understand, and I don't. The LHINs are planning for hospital care, they are planning for home care, and they start to plan for primary care. What makes it derail? I don't understand. You're saying that it wouldn't work, but I don't understand what it is that wouldn't work.

Dr. Scott Wooder: Well, our experience in engagement with physicians is that when you tell them what to do, even if it's the right thing, they're very cautious. But when you ask them what can be done to make a system better, they're very engaged, very productive, very constructive, and they will work to make the system better.

M^me^ France Gélinas: All right. But you never see a point where there could be some reluctant little physicians out there who need to be told to change their practice—or big physicians?

Dr. Scott Wooder: Well, the physicians' accountability is to our patients, and I think it's difficult to have that primary accountability to our patients if we're not autonomous health professionals.

M^me^ France Gélinas: If you're not?

Dr. Scott Wooder: Autonomous professionals.

M^me^ France Gélinas: So are you saying that everybody else who works within the system, their primary accountability is not their patients?

Dr. Scott Wooder: I'm saying that for physicians, we would have a very difficult time with that dual accountability to a LHIN and to our patients.

M^me^ France Gélinas: All right. So what do you make of physicians who work within the community health centres? They are employees of the centre, so they have accountability to their employers to keep their jobs. Are they not able to provide good-quality care to the patients they serve?

Dr. Scott Wooder: No, I think that some of the CHC physicians I've met are some of the finest physicians in the province. They give very good care. They enter into that relationship, that contract, with the CHCs on a voluntary basis. What I'm suggesting is that obligating physicians to do it in a non-voluntary way would be an impediment to the relationship.

M^me^ France Gélinas: So if it is offered to them and they select in, then that leads to good-quality care, but if they don't select in and they prefer to continue to bill OHIP, then there's a problem with quality care? Am I on the right path, finally?

Dr. Scott Wooder: No, no, no.

M^me^ France Gélinas: No? Still not?

Dr. Scott Wooder: I'm sorry. I apologize if I'm not being clear.

M^me^ France Gélinas: I'll get it eventually.

Dr. Scott Wooder: I don't think the payment model inhibits a physician's ability to provide high-quality care. Most physicians, certainly those outside of CHCs, are independent contractors. We are small business people—small businessmen and small businesswomen. We pay our rent, we pay our staffs, we pay all the overhead costs. It's difficult to imagine how a semi-government agency like a LHIN would go in and control all those small businesses and have a productive relationship.

There are also some implications that we're concerned about in terms of being seen by CRA as being employees. That's something I think that the government should be concerned about as well. The more we look to CRA like employees, the more they'll treat us like employees. There are implications for lots of things in the system if we were treated by CRA that way; the government might be treated as an employer.

M^me^ France Gélinas: All right. The LHINs are always very careful in saying they want to plan for primary care, but that would exclude payments to physicians. It's something that you support?

Dr. Scott Wooder: I don't see how you can separate the two things, how you can plan for physicians, tell them what to do and stay independent of the way they're paid.

M^me^ France Gélinas: Okay. I think I'm going to let it go around.

The Vice-Chair (Mr. Ted Chudleigh): Thank you. Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Chair. Thank you for coming in today. As we examine the Local Health System Integration Act, known as LHSIA, of course what we're really doing is looking at what the current status is and how that's working. As you've said, we've received a number of suggestions for change.

First, I'd like to just concentrate a little bit on how the system is working right now, obviously with a focus on

physicians. In relation to the physicians who work in community health centres, they are members of the OMA, I presume?

Dr. Scott Wooder: Yes.

Ms. Helena Jaczek: Do you have any way of getting feedback from those individuals to your primary care councils that you've established across the province in order to sort of get a sense of what their integration and interaction with the LHIN is, how it's working and maybe some examples of best practice that they may have found across those CHCs? Could you tell us a little bit about how that works?

Dr. Scott Wooder: Physicians who work in CHCs absolutely are members of the OMA. They have their own section within the Ontario Medical Association. I've had a chance to interact with many of their members over the years as the chair of the negotiations committee. I've met with and was very proud of the fact that in 2008, for the very first time, the OMA managed to get representational rights for those physicians and negotiate changes to their compensation. So they're very much part of the Ontario Medical Association and very important to us. They have direct feedback to the OMA centrally through their section at an OMA council. Also, they do participate in our primary care councils.

Ms. Helena Jaczek: So then, if you could tell me a little bit more about the primary care councils. As you've mentioned yourself, there are thousands of practising primary care physicians within each LHIN, so how do you develop your primary care council? Are these, just as an example, elected members of the OMA? How do you form to ensure that you've challenged—I guess, in a way—the LHIN of not having like-minded clinical leaders consult with them? How do you ensure that you get good representation in your primary care councils?

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Dr. Scott Wooder: The primary care councils are not an organization of the Ontario Medical Association. They are actually an organization of the LHINs. We've supported the development. We've talked to the LHINs and had some co-operation in developing these primary care councils, and we've provided some funding so that they can get established, so—

Ms. Helena Jaczek: So how big are these councils? Obviously you're saying that the LHIN organizes them, but you know how they're constituted, so could you explain the membership and the size?

Dr. Scott Wooder: It's not only physicians. Physicians are included, but other providers are as well. Institutions are invited.

In terms of size, it's a fluctuating picture. Most LHINs bring on people as needed for specific initiatives. I've been to a couple of meetings of the primary care council in my own LHIN, and there were 12 or 15 people present, including five or six physicians.

Ms. Helena Jaczek: So if this group is constituted to study a particular project, presumably there's an outcome, there's a decision—"This is the best way to move forward"—and that, of course, is the intellectual property of the LHIN. Does that, then, get fed back, because presumably it's a good thing that has come out of all this consultation? Does it then get disseminated in any way by the OMA to other practising physicians within that LHIN area? Is there any feedback beyond the area of responsibility that the LHIN actually has, which is pretty limited when it comes to primary care?

Dr. Scott Wooder: I would hope that our involvement would not just be in propagating the final outcome of the decision, but in communicating with our members before the decision is made. We would provide communications infrastructure, to get input from our members before the decision is made. That, to us, is the ideal model. Then, once the decision is made, we would be co-operative in communication.

Ms. Helena Jaczek: Okay. So, then, I understand that you try and get the grassroots input, so that the physician members on the primary care councils can provide that input to the bigger group, and that once some sort of implementation of some future project is decided upon, you then get back to the field. Could you give us any example of where that has worked well?

Dr. Scott Wooder: Peter, I wonder if you could—

Mr. Peter Brown: Thank you. That's an excellent question. I think one of the things I wanted to just highlight, before I answer your question directly, is that, as Dr. Wooder said, each of the primary care councils—the primary care networks—function a little bit differently. They set, in many cases, their own direction in terms of relationships and process.

One particular primary care network in the South West, again, is acting as the leader in much of what you're asking. They've established what they call a network of networks, which is taking that relationship that they're creating between themselves and with the other providers that have built into their primary care network, working with the relationships that they have with the diabetic groups, the renal groups, the hospitals and with the LHIN.

What they're ultimately doing is bringing the network of providers that they have, gathering the information and sharing it with their colleagues; learning from their colleagues about the care gaps, care challenges and care opportunities that exist within their LHIN; bringing that to the table; having that in a very strong conversation with the LHIN about opportunities and partnerships; and then delivering some results.

You asked about one specific result. Well, in this case, in working with the diabetic community, the primary care network was able to partner with their network of physician services within the LHIN to create 100% orphan diabetic attachment, which was a goal a few years ago, one that not all realized, but one we know is very beneficial to realization. That would be, I think, one example for you.

Ms. Helena Jaczek: You mentioned that these primary care councils or networks are kind of at different stages of development throughout various LHINs. Can you give any reason why, in some places, there is such

success and in others there doesn't seem to be the same progress?

Dr. Scott Wooder: I think that part of it is timing. Some of them are early adopters and get out of the gate quickly and they're more mature in the development of those primary care councils. Others have just more recently started to do it. I think it really is a function of time. With the maturity of the councils, they become more and more useful. Even in the LHINs where they're currently working well, we think they can work much better.

Ms. Helena Jaczek: Yes. So in other words, the structure is something that you think has good potential. It has proven itself in some places, but it needs to be replicated, enhanced—more maturity, etc.—and we've got something that is positive for patients.

Dr. Scott Wooder: We think the model is sound. It needs to be given time, as you say, to produce the best possible outcomes for our patients.

Ms. Helena Jaczek: In terms of how you have organized yourselves, I was intrigued that you have seven regional managers. Does that mean that each regional manager has responsibility for two LHINs?

Dr. Scott Wooder: Yes.

Ms. Helena Jaczek: Your boundaries are coterminous, in other words?

Dr. Scott Wooder: Yes.

Ms. Helena Jaczek: Okay. Thank you.

Perhaps we'll just ask a little bit about the relationship between primary care and CCACs. As we know, CCACs have a service accountability agreement with LHINs, and we've spent quite a bit of time talking about CCACs in this committee. We have heard of some successful models between primary care and CCACs. Could you elaborate, from the perspective of the OMA, how you see where some of this would constitute a best practice? In other words, liaising primary care physicians to the ability to refer their patients to the CCAC in getting feedback and consultation: What sort of model would you say is working well in the province?

Dr. Scott Wooder: We haven't spent a lot of time internally looking at the policy around CCACs, so unfortunately I don't think I'm in a position to answer that question.

Ms. Helena Jaczek: The regional manager might not have any perspective?

Mr. Richard Rodrigue: Certainly we do look at opportunities. We are looking at having an enhanced strategy to work with CCACs and connect physicians with CCACs this year. We're still evolving that particular strategy.

Ms. Helena Jaczek: We heard from one family health team member—I think it was last week—

Mr. Mike Colle: Dr. Martino.

Ms. Helena Jaczek: —Dr. Martino of the Brampton family health team out there—that they had a very successful liaison. I think he mentioned that once a month or so, there would be a complete review with a CCAC care coordinator in terms of plans for their patients who were currently receiving services through the CCAC. Is that anything you've heard much about?

Dr. Scott Wooder: It's very interesting; I started to practise in 1986, and when I started to practise, that's exactly the model I had. I no longer have that. Certainly, in my practice back in the 1980s, it worked very well.

I know the physician to whom you're referring. He's the past president of the Ontario college. I think he's very highly respected. He has had a good experience with it; it certainly mirrors the previous experience that I've had.

Ms. Helena Jaczek: I had the same experience in the 1970s. It got lost somehow.

Dr. Scott Wooder: It's not a competition.

Ms. Helena Jaczek: It's fairly self-evident that this should be something that happens.

Anyway, we've heard of one example. That might be something of interest, I would think, perhaps, to the OMA, because he did allude to billing issues around that particular forum where a patient's status was discussed, so that might be worth exploring.

Moving to family health teams: Family health teams, obviously, include primary care; that's their raison d'être, in essence. Have you seen any models where family health teams, perhaps through health links or in some other way, are looking at integrated services which are somehow being led by the LHIN or encouraged by the LHIN? What's that process? We're hearing a lot about health links, but only a few models are really active, I think, to date. What do you see as the potential for family health teams and health links somehow trying to develop best practice around integrated health care?

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Dr. Scott Wooder: We're very strong supporters of health links, as you know, and we've taken a leadership position, partnering with the Ministry of Health and Long-Term Care in developing policy around health links and are very supportive.

I can tell you my own experience. I practise in the Hamilton Family Health Team, the largest family health team in the province. There's another family health team in Hamilton, associated with McMaster University. McMaster Family Health Team has taken the lead in our local health link. It's a very large one, and they're working very closely with all kinds of stakeholders in Hamilton, including the Hamilton Family Health Team.

Because of the size and nature of the health link, it has been divided into regions, and the majority of people, both physicians and patients, in Hamilton are part of that health link.

I know that in other communities, family health teams are leading health links as well, and it seems to be a model that we're hearing from our members they've had a very good experience with.

Ms. Helena Jaczek: What involvement does the LHIN have in that? Is a LHIN planner involved, or is it directly between the Ministry of Health and Long-Term Care and the family health team that this is all taking place?

Dr. Scott Wooder: No, I think the LHIN's priorities are taken into account, and the health link tries to work in coordination with the LHIN's plan—very much so.

Ms. Helena Jaczek: Okay, thank you. Now, as you've alluded to, we've heard some fairly radical suggestions as we've travelled around the province. One was to do away with boards of community agencies, hospitals—and boards of health, presumably, as well. Do you have any comment in relation to that suggestion? It was made, in fact, by the former CEO of a LHIN.

Dr. Scott Wooder: We don't have an opinion about doing away with boards of those kinds of institutions.

Ms. Helena Jaczek: At this point, the OMA is not hampered in its activities—caring for patients—by boards of institutions, then?

Dr. Scott Wooder: No, we don't find it is an obstacle. We have a limited capacity to look at issues, and we prioritize them every year. That has not been one that we've chosen to take a close look at.

Ms. Helena Jaczek: Another suggestion was to put not only primary care within the scope of the LHIN but also public health. Medical officers of health are members of your association. Have you received any input from them as to how they're feeling about that suggestion?

Dr. Scott Wooder: No. Sorry, maybe I'm incorrect.

Interjection.

Dr. Scott Wooder: No. That confirms the no. We don't see any need. We think the Chief Medical Officer of Health does a very good job with the other regional public health physicians in providing that care.

Ms. Helena Jaczek: Okay, thank you. I don't think we've used up all our time, but we'll keep the remaining.

The Vice-Chair (Mr. Ted Chudleigh): Okay. Thank you very much. We'll move to the official opposition: Mr. O'Toole.

Mr. John O'Toole: Just briefly, I look at the questions that have been asked; they're quite informative. I've been here a long time, but not all that much time recently in health. But I was, fortunately, a PA for a while—three or four years—in interesting times as well.

I've listened carefully to the points that I think are quite relevant to the discussion. One is the role of the CCACs, for sure, and that has been asked by France as well as Dr. Jaczek; also the whole idea of integration of services—it's broader—and who gets left out and how does that funding stream separate itself out of half the budget.

I'd just remind you that we have a document out there—I'm not trying to politicize—that I think is quite thoughtful. I'm sure there were physicians involved in drafting our Pathways document—this one here—Pathways to Prosperity. There were three points in there that are rather relevant to the discussion here today on the streamlining and efficiency. I think everyone wants to make sure that the publicly funded health care system remains dependable, and properly funded, I guess, is an important part of it, but all that in the context of the document authored by the Auditor General prior to the last election.

Where we are today—and I'm quoting from the document; this is worth looking at. This is the 2011 pre-election report on Ontario's finances. This was the Auditor General's comments, saying that they're going to cut health care spending to balance their budget from a 7.1% annual increase from 2003 to 2011—that's each year, 7.1%. They're changing it to 3.6%. That is half the budget. It's huge if they don't deal with it.

They call it streamlining: the right service in the right place at the right time; all these various fancy words, which most companies have gone through, and you're a private sector business. How is this affecting you, this change here, just at the nurse level? They've cut 14 in one of my hospitals and seven in another. Where is the efficiency? Where is it coming out of?

Dr. Scott Wooder: Thank you very much for that question. This was very much the focus of negotiations between the OMA and the Ministry of Health in 2012. I had the honour to be the co-chair of the Ontario Medical Association negotiating committee. We took the position at that time that we recognized the fiscal problem that the province had and we wanted to do our best to help out, but that we wanted any changes to be based on, or at least informed by, best available evidence. We didn't want to propose cost-saving measures that would have a negative impact on patient care.

During that negotiation, we made a number of suggestions that were implemented into the final agreement. I'll give you a couple of examples. We eliminated the annual health exam for people between the ages of 18 and 64. That was based on evidence—very well-known, documented evidence—that a personalized health review was a much more appropriate intervention.

We also looked at screening intervals for Pap smears. We didn't want to hurt anybody by neglecting to provide the best possible care, but there was very good evidence that we could delay the onset of initiating Pap smears and increasing the interval between Pap smears based on the evidence.

There are a large number of similar types of examples I could give you. We ended up saving, through unrealized utilization, over $700 million a year.

In our opinion, and I haven't brought the evidence with me, we've significantly bent the growth in the cost of care associated with physician spending.

Mr. John O'Toole: Has the OHIP annualized budget decreased?

Dr. Scott Wooder: No. The rate of growth—

Mr. John O'Toole: That's the answer I wanted.

Dr. Scott Wooder: The rate of growth has decreased significantly.

Mr. John O'Toole: Yes, the rate of growth is by eliminating access to service. Basically, that's it.

You did the whole thing on Pap smear. As well, breast screening has been reduced, or at least the scientific argument is being presented that suggests it's redundant.

The reason I mention that: There are certainly motives for the current government, and, I suppose, future governments who really actually might have a chance of governing for looking at the 7% changing to 3%. That's really the argument here.

I appreciate—because you look after the OHIP negotiations, so you're saying. That's important.

Community health centres in my riding of Durham are quite successful, and the family health teams. Those family health teams aren't new as well. They were started under our government; they were family health networks. There was a great deal of reluctance in the negotiations at that time about the role of the doctor and who paid the nurse practitioner. That basically was the problem. The model didn't pump enough money into the system to satisfy.

That's primary care in a nutshell, the family health team—whether you need a nutritionist, psychologist or some other to deal with your primary stress or whatever it is causing your health issues. How do you respond to that? That's collaborative health. The model of primary care is collaborative health. You buy into that, I gather, the collaborative model?

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Dr. Scott Wooder: I practise in a family health team.

Mr. John O'Toole: Yes, that's what you were saying—in Hamilton.

Dr. Scott Wooder: I was on the board of directors of the Ontario Family Health Network, which was trying to implement the family health networks to which you've referred, so I'm very familiar with what happened.

I'd just point out that a minority of people in Ontario are served either by a family health team or a community health centre, so there is an equity problem associated with the services.

Mr. John O'Toole: Do you feel that's where they're trying to move to? In the collaborative model, everybody is sort of rostered with someone to get care. Isn't that really what they're doing? They're squeezing you out of the equation in terms of this independent silo under OHIP. It's going to get mushed into the primary care model and really do a number on the whole primary care with the family doctor—and the role of the nurse practitioner, as a nurse-practitioner-led clinic.

Dr. Scott Wooder: We don't feel squeezed out of that at all. We feel it's a tremendous opportunity. Interprofessional care is something we believe in very strongly. We think that we can make use of each other's skills, talents, backgrounds and experiences to provide the best possible care for our patients.

Mr. John O'Toole: That's good. I'm not an expert by any means. I'm just really concerned about how they're going to—it really is that you are getting more—you're eliminating services to be able to maintain the fundamental bucket that you have now.

We see the comments on the CCACs as spending an inordinate amount on administration, so we're not really in that whole grouping everything under the LHIN. Two or three of our recommendations are pretty helpful. I think number 12 says "fundamental strengthening of our health system by making one-time improvements in efficiency ... such as eliminating administration in LHINs and CCACs...." How would you respond to that? I mean, it's the regional model right now.

Dr. Scott Wooder: We're not talking about eliminating services. We prefer to think about it in terms of not doing things that aren't supported by evidence, so that we can provide good care that is supported by the evidence. So it is not doing things that don't make a difference for people's health, and making sure that the things we are doing have a very firm evidentiary basis.

Mr. John O'Toole: It's certainly supported by what you said, but in the public's view, especially women's health, it becomes political, really. I'm not in a position to decide one way or another. You're the voice that we need to hear from. You're a trusted voice that is independent, and it supports your case of independence, really, of saying, "Who is a group that we can talk to?" Certainly, the OMA is that group, from clinically based decisions on reducing perhaps some routine stuff, I suppose you would call it.

Do you think there's any advantage in them looking at themselves, looking inward at the CCACs and the LHINs, to find efficiencies there, put them on the table, put a number and require them to have one system—the data systems, the payroll systems, the backroom stuff? Are you satisfied that the 14 LHINs are doing anything in that direction today?

Dr. Scott Wooder: I think we should all be obligated to look at the way we conduct ourselves and find efficiencies wherever possible.

Mr. John O'Toole: Those are really good answers. The thing is, I recall going—when eHealth came in, I was on the Smart Systems for Health board for about 10 years, and my background was systems; I was a COBOL programmer. I remember the OMA pulled out of it at the last moment. They were on board for the eHealth—the privacy issue became the issue, and it sort of got pulled off the table—that is, the legislation. Since you've been there so long, you would remember that discussion with Elizabeth Witmer, I'm sure.

I just remember that the issue there was about looking at over-doctoring, over-drugging—all the efficiencies of looking at your records to see whether a doctor is not appropriately prescribing or is over-prescribing or whatever else.

There are about three or four systems operating today under the other—it's eHealth today, but it was Smart Systems for Health. There were about nine modules. They looked at drugs, labs, long-term care, emergencies. These were all independent systems that you looked at the model to manage efficiencies. What's your view on having one system for every doctor, whether it's with the tablet that we had—the tablets were out there. It would almost diagnose for you. You would check off this symptom, symptom, symptom. The reason I'm asking that is, there is a lot of money, over $1 billion since 2005, I think, in eHealth—for part of that, there was another $1

billion spent—and we don't have a system. You're talking about this new system, the health links, I guess it is—there's the federal system; it's called Health Infoway. Is there one system, and do you think you should all—doctors' offices and everybody—have the same system?

Dr. Scott Wooder: There's been great success in digitalizing primary care records. Ten million Ontarians have an electronic version of their medical record in their family physician's office. The concern we have—and it's not unique to us; I think it concerns everybody—is the lack of connectivity between various parts of the health sector, not being able to view the information that's contained.

The other issue that you brought up that's really important is data extraction and analysis. We're firm believers that, on a practice basis, we should be providing information back to practitioners about how they're doing in drug prescribing or test ordering or other quality indicators. You know, what are your results in terms of your diabetic management? We'd like to feed that back to the physicians. There's a lot of evidence that when you do that, when physicians discover that, somehow, they're an outlier, that they prescribe a lot more antibiotics than their peers do, they will reflect on their own practice and change. We're not in favour of doing this in a punitive way, of saying to somebody, "You order too much of this test or this drug," but giving the information back so that they can change their practice. We're convinced based on evidence and experience that physicians will take that—

Mr. John O'Toole: Who should be doing that assessment and analysis? Should it be the OMA or should it be the LHINs?

Dr. Scott Wooder: We have a proposal, not that I can talk about it in detail, but we certainly have a proposal that we would be interested in helping extract that data and feeding it back to our members.

Mr. John O'Toole: I could probably go on for a while. I'll save some time for my colleagues. Thank you very much for being here and for your straightforward answers. I appreciate it.

Dr. Scott Wooder: Thank you.

The Vice-Chair (Mr. Ted Chudleigh): Do you want to do it now?

Mrs. Jane McKenna: Yes.

The Vice-Chair (Mr. Ted Chudleigh): Go ahead.

Mrs. Jane McKenna: Thanks so much. It was nice meeting before we started here today. I have a couple of questions. I guess my number one question is this: You have on page 2, "Successful LHINs have found ways to engage physicians in timely and transparent ways to achieve." After eight years, don't you think they should all be successful?

Dr. Scott Wooder: We would hope they'd be more successful, and we would certainly be happy to facilitate that.

Mrs. Jane McKenna: We've heard numerous times, over and over, in here that they're in silos and not one communicates with the other. So I think if I knew a successful LHIN was doing extremely well and doing clearly what you need to be engaged as physicians, that it would be imperative—since the success of how everybody streamlines is exactly what you're saying is the success of the patient, we're clearly missing the mark of the patient, then, if not everybody's successful after eight years, wouldn't you say?

Dr. Scott Wooder: I think we're on the right track, in that we do have some structures in place that will improve communication between providers and the LHINs and patients, everybody involved, all the stakeholders in the health care system.

Mrs. Jane McKenna: I'm curious as to what exactly that would be, because you're talking here, first of all, about partnerships for the planning for the primary care with the LHINs. We've had numerous times, over and over again, in here that they think they should be doing the primary care completely by themselves. I wonder why they think that, unless they see a flaw in the system of what's happening. Now, do you know why we've heard that numerous times, that all of a sudden now they want to do that? It's curious.

Dr. Scott Wooder: I think I'd be speculating about their motives.

Mrs. Jane McKenna: They're speculating?

Dr. Scott Wooder: No, I don't want to speculate—

Mrs. Jane McKenna: Oh, you don't want to speculate.

Dr. Scott Wooder: —as to their motives. Sorry.

Mrs. Jane McKenna: Okay. I'm just wondering, if we don't have the partnership, you said the survey that you spoke to Ms. Gélinas about—you did a survey of 1,000 doctors. I think you said two thirds—you can correct me if I'm wrong—felt that they couldn't even figure out how to talk to the LHINs to get the answers that they needed to be part of the process. So how's that partnership working right now?

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Dr. Scott Wooder: There's certainly room for improvement.

Mrs. Jane McKenna: Yes. But I guess where I struggle is, as MPPs, we're all supposed to know our job description and know what that is. After sitting in this—I've been part of this process since the beginning. I'm just curious as to how we figure out what everybody's job description is so the person you're supposed to be taking care of, which is patient-centred, actually gets taken care of, without all of this minutiae. There just seems to be so much going on after eight years, except for the patient. I struggle, being in here, with that.

You talk about primary care. You talk about there being 1,000 people who are in the primary care council. So what happens with all that information? Is it just another layer of bureaucracy? I'm just wondering why we need someone else to do that for us. Were we not capable of doing it ourselves before we got this council going?

Dr. Scott Wooder: When I started a practice, I knew that if my patients would just do what I told them, they'd be so much better off. I had to unlearn that very quickly,

because it doesn't work that way. In fact, what I have to do is have a discussion with them, engage them. I kind of regard myself as an adviser, as a mentor, as an educator, helping them make the right decision.

It's taught me a lot about engagement within the system, that the top-down approach doesn't work. That's my concern. That's a concern of the doctors of Ontario in having primary care somehow under the control of LHINs. We think that's not the right approach. The right approach is to engage grassroots physicians, nurses, personal support workers, the people who are actually providing front-line care—institutions, hospitals. Have them give information to the LHIN. The LHIN has to plan and coordinate. Absolutely. I agree with all that. But we don't want to be put in the position where the LHINs are telling individual practices what to do, individual physicians what time they should have their offices open or whether or not they're allowed to retire, what model of care they should be in. I think that's the wrong way to go about it.

Mrs. Jane McKenna: Okay, then just one other thing. I guess, in the 21st century, when you're talking about not being able to communicate, some of the physicians—you know, everybody has different hours and times. I find that so hard to believe in this day and age, when there are so many places we can go to, that you can have people talking at any time of the day. If it's so important to fix what we're doing right now, and we're trying to get the recommendations to do that, why is it that we don't all just try to figure out what that is, so if it's 7:30 in the morning, we can all figure out how to do 7:30 in the morning? Because if you're not part of the solution, you're part of the problem.

Dr. Scott Wooder: I know that from a physician perspective, sometimes we're overwhelmed by the amount of change that we've gone through. If I reflect back on the last 10 or 15 years in my own practice, the number of changes that have gone on, I've gone from being a physician-only practice to an interprofessional team. I've gone from being a paper-based practice to being an electronic practice. Our payment models have been changed. The emphasis on evidence has dramatically changed, that we no longer rely so much on expert opinion and past experience, but we actually look at the evidence of what works. All these changes taken by themselves make a lot of sense, but when change all comes at a group together, it's overwhelming sometimes. Sometimes just one more thing for physicians is just too much for them to manage.

Mrs. Jane McKenna: Wow. That's concerning.

Dr. Scott Wooder: Well, I guess I'm an optimist. I look at all the great things that have come about because of all that change and all the great work that's been done by individuals and groups. A physician who was mentioned earlier—he's been a leader. Lots of physicians are doing great work, and lots of nurse practitioners, physician assistants. There's lots of really good things that are happening. So that's what I prefer to focus on.

Mrs. Jane McKenna: I'm going to pass this off to my colleague.

Mr. Bill Walker: Thank you. Could I just ask how much time's left, Mr. Chair, so I can understand?

The Vice-Chair (Mr. Ted Chudleigh): You've had 19 minutes so far. You've got another 10 minutes to go.

Mr. Bill Walker: Thank you.

Thank you very much—very informative. Your second paragraph on page 2 suggests: "It's not clear to me that the people who have proposed the idea of moving primary care under LHIN control have a full understanding of either the current system or how extensive and disruptive the change would be."

I guess I have a couple of concerns. One would be that I'm sensing, obviously—and I'm relatively new to the Legislature, so the learning curve is still pretty steep—that there was not a lot of prior consultation before this model was imposed upon the system. We've now had eight years, though. You're still concerned that there are not people in the process who truly understand the current system or how extensive and disruptive the change would be. Could you elaborate on that a little bit?

Dr. Scott Wooder: Yes. I think the passage you're referring to is the lack of understanding that has to do with proposed changes, not the current system, so a proposed change whereby LHINs took over control of primary care. That's the concern that we're expressing.

Mr. Bill Walker: I guess the concern I would have if I'm the general patient out there—who we should all be focusing everything we do on. They're not—the people in my riding of Bruce–Grey–Owen Sound—relatively comfortable that the LHINs are doing a great job and a bang-up job, currently, for their health care. So if the feeling from them is that they've truly implemented a system that's not working extremely well already and they've not consulted and understood what the ramifications are of adding yet more change, why would we be moving ahead with this? Why would we be adding more change to a system when the public does not feel comfortable now? I believe, again, that the two thirds number that you shared with us of your membership suggests that they don't feel comfortable that they can even have a dialogue and a lot of ability to have good impact and influence. It seems strange to me that we would be moving forward, then, until we actually satisfied the patient that we've got a good working system in place.

Dr. Scott Wooder: We're not proposing any changes to the current system. We think that the LHINs need more time. We welcome the input they have allowed us to give, but we don't support any significant changes with regard to our members.

Mr. Bill Walker: We've had eight years to implement this system and you're suggesting more time. What type of a timeline are you looking at to actually give the patient comfort that we have a well-functioning system that truly serves their best interest?

Dr. Scott Wooder: I'm not sure that I'm really the best person to ask.

Mr. Bill Walker: Can you give me broad strokes? Are we talking like a year? Are we talking five years? Or are we talking another eight years?

Dr. Scott Wooder: I think we've seen some changes, we've seen some improvements. The development of the primary care councils—it's still in its formative stages—I think has been a positive development. I think the excellent work that we're doing together on health links is another example of some things that, under the current structure of a partnership, are working well.

Mr. Bill Walker: You've referenced now—I'll move a little bit into the health links. It's interesting that these health links have come along at the end of the eight-year implementation period. I'll be a little bit aggressive and suggest that there was a health hub reference in the product that my colleague from Durham referenced, and not very long after, health links came out, which may be just circumstance; it may be ironic that they happen to be there. But where were they in the first eight years?

I'm getting most of this back to—what I'm finding here, being a member of Parliament in the last two and a half years, is that most of these initiatives are thrown onto the public. They're imposed on people like the medical community or other areas of our province without a lot of prior consultation to ensure that it's going to work, to ensure that it's actually going to be able to be implemented for the benefit of the person at the end of the row, whether that's health care or whatever industry we may be looking at.

So I find it interesting that, again, we're now eight years in and now we're looking at a link. Why wouldn't that link have been there in the first process? Where were you? I think you've been a little bit concerned that you weren't at the table as a true stakeholder from day one, being able to have input into the system.

Dr. Scott Wooder: I can't speak to why, in terms of priorities, it came up when it did. I can say that we've chosen to regard it as a forward-looking development, one which we support and want to make successful, because we think that in the end, it will help improve the quality of care that we're able to give to our patients.

Mr. Bill Walker: So you're comfortable that the health link is an enhancement. You're comfortable that you, as the OMA, are truly going to have a stake at that table and a true voice?

Dr. Scott Wooder: I think that's been our experience and we're very hopeful that it will help improve the quality of care in this province.

Mr. Bill Walker: You mentioned a little while ago that you had real concerns in regard to the payment model and how you were going to retain being an independent businessperson and yet be treated almost like an employee to some degree. Can you share with me—do you truly believe that there's a system currently in place that's going to work tomorrow to allow you to have that dual role, with the current LHIN structure that is in place?

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Dr. Scott Wooder: I think the key is the relationship between the LHIN and the physician. Our contention is that a voluntary relationship, one that's built on mutual goals of integrating service and doing what's best for our patients—now, that's the model that we support. We don't support the hierarchical model, where the LHIN is in charge and dictates to the physicians what they should be doing. We think we should be equal partners in this discussion, bearing in mind that we both have ultimately the same goal, which is to improve the care that we give to our patients.

Mr. Bill Walker: Okay. A final one for this go-around: It certainly seems, again, from a lot of the feedback that we're getting—and I think my colleague from Durham referenced earlier that approximately 40% of a CCAC budget goes to administration. We know that a fairly high percentage of the LHIN budget goes to administration, supposedly to coordinate services. You've been in the business since the 1980s, I believe. As a naive young guy—a little younger than that, at least—I would suggest that there's a Ministry of Health that has a fairly large contingent of people, and now we've added yet two more layers in there that seem to do a lot of time spinning paper as opposed to the front-line health care that my constituents are asking for.

Do you have an opinion, as the OMA, that there would be a potentially better model that would go directly between the provider and the Ministry of Health, which is charged with the responsibility for the successful operation of the health industry?

Dr. Scott Wooder: Well, we certainly want to make sure that resources are in place to provide direct patient care.

Mr. Bill Walker: You're not really suggesting if you feel that there's a better model than the two that are currently existing.

Dr. Scott Wooder: Well, for instance, the notion that CCACs spend 40% on administration—I'm not an expert on that. I believe that includes case management, which isn't done at the bedside but is absolutely necessary to coordinate the care for individual patients. Again, I'm not an expert in that. I'm really giving my own opinion on that, which probably isn't as helpful as an actually fact-based position from the OMA.

Mr. Bill Walker: Thank you. I'll turn it back to my colleague from Durham.

Mr. John O'Toole: Thank you. It's very helpful. I have great respect for the OMA. They have traditionally—this probably sounds like you. Physicians continually, as you said, want to be engaged in a real, meaningful way. Basically you've run the system for years, respectfully, as a profession. You have a college and a union of sorts—this professional association—that is able to find agreement with the government on the pay scale side and on the ethics and the procedures of the college and what's the scope of practice etc., and that's a commendable thing. I understand, and I would probably support

the view of the OMA when it comes to looking at the role of the LHIN.

As well, I find in my area they have improved. Because they have—I forget what the acronym stands for—an integrated service model, where they are picking winners and losers, whether it's thoracic stuff. They pick these priority areas, which I think are dictated by some medical models of, "What does the chronic health care model look like and where could we get the best bang for the buck?" That, to me, implies collaborative delivery of service. In all cases, you don't need a thoracic surgeon talking to someone who's got a bad cough. Do you understand? So who provides the service is where the changes are occurring now, independent of you, I think.

Increasing the scope of practice for nurses has been phenomenal for the last, I'd say, 10 years. We started it by changing the scope of practice. I think that's the future. I do believe that there needs to be highly paid and highly motivated professionals, whether it's at the cardiac, neurology or all these different levels. I think the persons getting squeezed here are the GPs, who basically, in your 30,000-member votes, are the majority of the votes. I think the professionals—the cardiologists, the neurologists, the orthopedists and all those—want OR time. It's about where the money is. I don't disrespect.

Amongst yourselves, are there subgroups within the OMA that might have a different position than yours? Because we can't afford the system, unfortunately. Lots of people in my riding, even today, are waiting, with an aging population, for the right drug—Esbriet, for IPF. That's being denied, despite clinic evidence that it should be prescribed. Doctors are writing me, because if they're a respirologist, they think Esbriet is the proper drug. Now, the ministry is just locking in. Deb Matthews, in all due respect, is saying—

The Vice-Chair (Mr. Ted Chudleigh): Could you wrap up, Mr. O'Toole, please?

Mr. John O'Toole: —no to most of those drugs. I guess I'm saying to you, because we don't get to talk to you professionals too often, your views will be accepted more readily by the public than almost every other view. The really high degree of receptivity for nursing—nursing has got a lot of public leverage on this discussion, and they're your natural partner at the bedside and in the OR.

The Vice-Chair (Mr. Ted Chudleigh): Mr. O'Toole, your time is gone.

Mr. John O'Toole: I just need one minute to finish my argument.

The Vice-Chair (Mr. Ted Chudleigh): No, your time is gone, Mr. O'Toole. I'm sorry.

We'll move to the third party. Thank you very much.

M^me^ France Gélinas: How much time do I have, so I use it wisely?

The Vice-Chair (Mr. Ted Chudleigh): Fifteen minutes.

M^me^ France Gélinas: Okay. My first question is just a cleanup question again. You use "we"—I think sometimes it means "we" as in Ontarians; sometimes I think it means physicians. This time, you said, "Primary care councils belong to the LHINs, but we provided some resources." Who is "we"?

Dr. Scott Wooder: The Ontario Medical Association provided resources, funding, to the LHINs to set up primary care councils—not a lot of money.

M^me^ France Gélinas: Where does this money come from?

Dr. Scott Wooder: From our members' dues.

M^me^ France Gélinas: All right. So you provided it directly to the LHINs or to your members on the LHINs?

Dr. Scott Wooder: Richard, could you help me out?

Mr. Richard Rodrigue: Mostly in supporting the meetings, so directly to the primary care networks or councils. Usually it's to help fund meetings so that they can happen.

M^me^ France Gélinas: Can you give me an idea of how much money we're talking about?

Dr. Scott Wooder: I heard today in the neighbourhood of $5,000 per LHIN. As I said, not a lot of money, but enough to help facilitate meetings, bring people together, have discussions.

M^me^ France Gélinas: Per LHIN or per council?

Dr. Scott Wooder: Per LHIN. There's one council per LHIN.

M^me^ France Gélinas: Okay. There's seven regional engagement managers—

Dr. Scott Wooder: For 14 LHINs.

M^me^ France Gélinas: —for 14 LHINs and 14 councils.

Dr. Scott Wooder: Yes.

M^me^ France Gélinas: Got you. All right. That was just a little cleanup.

My other little cleanup: If I understand well, you see the future of primary care integration as in the providers coming together—and you said physicians, nurses, long-term-care homes, hospitals, PSWs—everybody comes together and feeds their advice, we'll say, to the LHINs, and then the LHINs plan and coordinate. Am I starting to better understand what you're saying?

Dr. Scott Wooder: Yes.

M^me^ France Gélinas: All right. I admit, I'm surprised that I'm following on—he and I don't usually follow in the same line of talk, but it seems like we are. Why are you feeding that to the LHINs and not to the ministry directly?

Dr. Scott Wooder: We're not shy about sharing our opinion with everybody. So we tell the ministry. We tell everybody who will listen.

M^me^ France Gélinas: But the structures that you have used some of your membership dues on and that you have been supporting is really a structure where you allow people to meaningfully give their advice to the LHINs.

Dr. Scott Wooder: That's absolutely right. You know, we think that it's important for us to not only give advice to other people about how they could spend money, but we want to make an investment in making things better. We will spend members' dues to do that.

We do that now in supporting our members to develop their leadership skills. There's a number of other initiatives that wouldn't seemingly be a usual way that a professional association would spend its resources, but we're willing to do that to make the system better.

M^me^ France Gélinas: Is there any brainpower being spent right now within the OMA that looks at what the future of primary care integration is? What could it look like? Where is this work being done and what does it look like?

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Dr. Scott Wooder: Yes, there's a tremendous amount of effort and brainpower; I'm looking at Mr. Brown because he's the big brain. I gave a lecture at McMaster University last week, and I talked to a group of students—not all medical students; there were nursing students, pharmacy students, PA students there. We were talking about interprofessional care. I told them a story about my own practice. When I started, I went in with two other physicians—actually, I took my practice and joined them. They had registered nurses working for them, but the registered nurses were answering the phone, they were filing, they were booking appointments, and they were giving advice to patients. That's not working to full scope of practice. We changed things. We hired administrative staff to do administrative work, and we changed it so that our registered nurses were doing things that registered nurses should do.

I also want to work to the full scope of my practice. I don't feel squeezed out at all. The ability to work with a team has changed my function to much more of an executive level. I make big decisions with patients. I'm not necessarily giving vaccinations, checking blood pressures and jotting down medication lists in the chart. I have other people who do that, and that is within their scope of practice.

An integrated interprofessional team allows me to do that and function at a much, much higher level than I was doing 25 years ago. That's our view of the future.

M^me^ France Gélinas: Okay, so could you expand a little bit as to what this team would look like? Who would be part? How many people would take part? How would it work?

Dr. Scott Wooder: Sure. It really depends on local circumstances. In the region of the province you're from, there are communities that have few or no physicians, so they would have a very different structure from where I live in Hamilton, where there are 350 family physicians, and we have 150 physicians as part of the Hamilton Family Health Team, and another 40 are part of the McMaster Family Health Team. So I don't think there's one formula that works across the province. I think it's up to individual communities to make decisions about who should be part of the team. That depends to some extent on what other resources are available.

Recruitment is a big issue, too. I would love to work with a physician assistant; I have trouble recruiting one. I know other people would like to work with a nurse practitioner, and they're just not able to compete with the hospital sector in terms of salary.

I don't think there's one model. I think the key is interprofessional teams working together for the benefit of the patients, everybody working to their full scope of practice, and having regular communication to check back with each other to make sure that these teams are functioning at a very high level. That's how we see the future.

M^me^ France Gélinas: Okay. I like the future. Talk to me a little about how, in this view of the future of integrated primary care, payment for all this fits in. You and I have already talked. I see fee-for-service as an impediment to working as a team, because you have the rest of the team that is on salary and has time to do this important dialogue between team members, and then you have one member of the team who is paid a fee for service, and if he or she takes the time to review a patient with you when the patient is not there, they lose out. They're the only loser in the room.

Dr. Scott Wooder: Well, I can assure you, physicians are rarely the loser. We do very well.

I haven't personally been in fee-for-service for 25 years. I've been in a capitated model during that whole time. The majority of comprehensive care family physicians now are being paid largely through capitation. The rest are being paid on a blended model which includes a portion of capitation. I believe, with bonuses and the capitation components, 25% of their income comes from capitation.

You're right: Even for those people, there is a barrier to working within teams because it has a negative impact on the physician's revenues. It doesn't on mine; I'm capitated, so I don't suffer that. But someone for whom the majority of their income comes from fee-for-service—it's not just the time taken in consultation, but it's the alteration in case mix.

We all see people with incredibly complicated medical problems who need to have a lot of time spent with them and their families. Then we see people with very brief, self-limited illnesses—a 30-year-old man with a cold. It's a very brief interaction. The payment for those two encounters is likely the same. So if there's a nurse practitioner who is part of the team and who sees the 30-year-old with a cold, then it alters the case mix, and the physician—it will have a negative impact on their revenue. But in family health teams, none of the physicians are fee-for-service; they're all paid through capitation. The majority of comprehensive care family physicians are. The model is being encouraged by the Ministry of Health, and the numbers are increasing, month over month.

M^me^ France Gélinas: So this is kind of your view of the future, where most physicians would be in an interdisciplinary team practice setting and being paid through capitation?

Dr. Scott Wooder: Being in an interdisciplinary team setting where the payment model didn't interfere with that, whatever the payment model was, yes. So it could

be salary, for instance, in a CHC. That's how they're remunerated and it works quite well.

M^me^ France Gélinas: Okay. You did mention a little bit about incentive payments. Those can also have interesting—I would say unintentional—consequences. You want to do something good and then you realize that, because this is incented and this is not, they end up doing this rather than that. What is the OMA future of primary care integration thinking about that?

Dr. Scott Wooder: You're absolutely right: Some of the incentives we've put in place have unintended consequences. Some of the incentives we've put in place are overtaken by new evidence. An example of that would be an incentive that was put in place to do Pap smears every two years, whereas current guidelines would suggest that every three years would be a more appropriate time frame. There were incentives put in place for certain childhood immunizations. Well, since we put those incentives in place, the list of childhood immunizations has grown.

The way we do that is that there's a joint OMA-Ministry of Health committee called the physician services committee that would review those on a regular basis. They would have a subcommittee that looks specifically at primary care and would review those incentives to make sure that there were no unintended consequences, or if there were, to make changes, and to make sure that the incentives were based on current evidence, not the evidence that was in place at the time the contract was negotiated.

M^me^ France Gélinas: Okay. So I have a different point of view. Why do you have to pay incentives for physicians to do the right thing? Every other health professional does the right thing because it's the right thing to do and doesn't need an incentive to get paid. But you don't have to answer that if you don't want to.

Dr. Scott Wooder: No, I don't disagree with you. Those incentives were not add-on payments. Those incentives were made in lieu of increases to the schedule of benefits. Our members would have much preferred to have not had the incentives put in place and just have had the increase.

M^me^ France Gélinas: Good answer.

Dr. Scott Wooder: I've been practising that one.

M^me^ France Gélinas: So in all of this conversation, I don't see a role for the LHINs in there. We're here talking about the LHINs; all of this future of what primary care could look like sort of makes sense to me. I would say that I would be ready to support a lot of what you've said, but I fail to see why we need the LHINs to get there.

Dr. Scott Wooder: Well, I can give you a theoretical example. A LHIN identifies a certain area of practice as a priority: diabetic management, improving end-of-life care, improving child-maternal health—something like that. They then go to the primary care community and say, "This is our concern; this is what we want to do. What's your experience? What changes should we put in place? How do we solve the problems we have in common?" Then they would act as partners in coming up with solutions, developing programs to improve care in those specific areas. That's the role I see of the LHIN.

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M^me^ France Gélinas: All right. So this comes back to the conversations you were having where the LHINs would get an informed opinion as to what other programs and services are needed and identify those areas of practice as a priority. How do they become a player in making sure that those areas of practice get picked up?

Dr. Scott Wooder: Physicians want to do the right thing. It's our training. It's a professional obligation that we have. That professionalism stretches back generations. We don't need a LHIN to tell us to do the right thing. We may need their help in deciding what the right thing is, and they may need our help deciding how to do that. But we don't need the LHIN to somehow sit as an enforcer of our professionalism.

M^me^ France Gélinas: Okay.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. Your time has expired.

Ms. Jaczek.

Ms. Helena Jaczek: How much time do I have left, Chair?

The Vice-Chair (Mr. Ted Chudleigh): Fourteen minutes.

Ms. Helena Jaczek: Thank you. Dr. Wooder, I'll pick up on something you said to the official opposition. You did say that with the LHIN structure, we're on the right track. You apparently started practice in the 1980s. You will no doubt recall, as do I, all the discussion around regionalization of health care. The concept—and this was happening across Canada in the 1980s and the 1990s—was that health care decisions should somehow be made more at a local level as opposed to in the ivory tower in the provincial Ministry of Health. That was, I think, a consensus view that developed over time. I'd like to point out to the official opposition that it was our government that actually took some action here in Ontario with the structure that we have in front of us, and further to that, given the complexity of the health care system, if we can call it a system—in other words, the number of players here in Ontario, a province with 13 million—this has been a complex, difficult task.

Perhaps there's a lack of understanding by some that changing from what we had before to even where we are now has, not at all surprisingly, taken a considerable length of time, as you've alluded to yourself. The change that has happened in medicine and the change that we have brought about through the Local Health System Integration Act is considerable, and it engages so many different players and so many different organizations.

I guess I'll ask you the question, then: You were practising in Ontario. We had district health councils. We had the Ministry of Health. Would you say that what we have now is an improvement?

Dr. Scott Wooder: Yes. I think the improvement is the whole change of philosophy, that we need a system. You question whether we have a system. Certainly, we

have more of a system than we did when either one of us started practice. Do we need to go further? Do we need to improve that? Sure, but we're on the right track.

Ms. Helena Jaczek: Let's turn it over to you a little bit to give us your ideas. Officially, this committee is looking at the act itself, the legislation. Has the Ontario Medical Association determined that there's any need for change to the legislation?

Dr. Scott Wooder: No, we don't have any specific recommendations about a change.

Ms. Helena Jaczek: In other words, what we're talking about is that within this framework, how can we make things better for the patient in Ontario?

Dr. Scott Wooder: Absolutely.

Ms. Helena Jaczek: One of the things you've said on behalf of the medical profession is clearly a partnership between the profession and the LHINs in terms of moving forward. Is that fair, that that would be the kind of relationship you would like to see?

Dr. Scott Wooder: Sure. We'd like to see a partnership with the LHINs, with the Ministry of Health, with the government, with the people of Ontario, with our patients, with the hospitals. It's the type of relationship—the partnership relationship—that actually works in making things better.

Ms. Helena Jaczek: If you were suddenly to be made the CEO of a LHIN, what would you do? What would be your types of actions? How would you reach out? Describe to me what you would do in that first three months on the job.

Dr. Scott Wooder: Well, in terms of better understanding the position—I'll stick to that, because that's what I know best—I would engage some lead physicians, people I trusted, people I paid, to go out and speak to as many physicians as possible. I wouldn't invite them in. I think there's a huge difference between inviting a physician to your place and going to meet them.

When I was elected to the board of the OMA, our approval rating amongst members was about 30%. It now stands in excess of 70%, and a large part of that, I believe, is that in 2004 we instituted a program where we would go out and meet members where they lived. Prior to that, we had meetings in council—usually here in Toronto; sometimes in Hamilton, London or Ottawa—but it was a fairly new thing. During my term as president, I've been to Timmins, Sudbury, Thunder Bay, North Bay, Windsor—I've been all across the province, and my predecessors and successors will do that as well.

The key there is going out to see the members, not inviting them in. And I'd ask them what changes they would like to see made. Some of the ideas won't make a lot of sense, but some of them will make a lot of sense, and understanding the motives behind even the ones that perhaps won't work will help inform.

The first thing I would do would be to go out, talk to people and ask them what changes need to be made.

Ms. Helena Jaczek: How would you better utilize the primary care councils? Do you think there's a way of beefing that structure up?

Dr. Scott Wooder: I think the primary care lead, who is a physician engaged by the LHIN, should be the person who goes out and does the engagement. They're usually, I believe, the chairs of the primary care councils, so I would use the people on the council—people who are volunteering to come forward—to engage in that. I would use them, their expertise and their contacts to go out and speak to front-line workers—physicians, nurses—and everybody who actually provides care to patients.

Ms. Helena Jaczek: And how would you perhaps—we've heard some criticisms about LHIN board meetings being very poorly attended. People don't know that they're happening. Usually, at least in my LHIN, they occur at night. Is there any way to engage more physicians in just hearing about the general business of the LHINs, or somehow engaging them better?

Dr. Scott Wooder: I'm not sure that attending a board meeting is the way to engage physicians. I think that some of the things that happen at boards—probably most of the people in this room have been on a board. There are a lot of fiduciary things that go on. I think that going out and talking to people where they live, talking about clinical and patient-related matters, would probably be more important than attending a board meeting.

Ms. Helena Jaczek: So, in essence, you feel that there's a lot of communication that is necessary, improved communication, treating physicians more as partners. You've talked about the top-down approach not working. In essence, you see stay the course; just simply improve the quality of the interactions. And—this is something that we've heard—ensure that, wherever there is a best practice, and there was a reference to South West, that this somehow be disseminated in a more effective manner across all 14 LHINs. Would you say that that's pretty much your position?

Dr. Scott Wooder: I think that everybody in the health care sector wants to do the right thing. They want to learn from their colleagues and peers who are maybe more successful in a particular area. So yes, I think that disseminating those best practices is important.

The key word used was "communication." We need to improve, too. The Ontario Medical Association needs to improve the way it communicates in this regard.

Ms. Helena Jaczek: I have no further questions.

The Vice-Chair (Mr. Ted Chudleigh): That concludes our session. Thank you very much for your patience, your understanding, and your knowledge that you've imparted to the committee. We appreciate it very much. Thank you.

Dr. Scott Wooder: Thank you, Chair.

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TORONTO CENTRAL LOCAL HEALTH INTEGRATION NETWORK

The Vice-Chair (Mr. Ted Chudleigh): Next, we have the Toronto Central Local Health Integration Network. Thank you very much for coming in. You have up to 15 minutes for your presentation. Any time remain-

ing will be used for questions from one, two, or three of the parties. Thank you very much. Could you identify yourself for the purpose of Hansard, please.

Interjection.

The Vice-Chair (Mr. Ted Chudleigh): Has there been a presentation circulated? No, I'm sorry, there has not been a presentation circulated. There's a background paper that has been circulated. The presentation has not been.

Ms. Camille Orridge: No. We're just getting it.

Good afternoon, and thank you for welcoming me back as you continue your review. My name is Camille Orridge, and I'm the CEO of the Toronto Central LHIN. You may recall the presentation I made to this committee in December, speaking as a representative of all 14 CEOs across Ontario.

In the past three months, you have travelled to different communities, from Windsor to Thunder Bay, collecting local expertise and hearing from communities all across this province. I commend you all for the time you have taken—that's a lot of listening—as we review the legislation.

While this committee took part in these local hearings, I've had my own encounter with the health system right here in the Toronto Central LHIN. I would like to take this opportunity to speak to you not only from the system perspective that the LHINs give me, but also to convey my recent experience as a patient, and another experience as a caregiver. I have learned a lot from my health care experience as I went through the system. I was able to highlight and identify what worked for me and what didn't. I hope my remarks today will underscore the integral role the LHIN plays as a local voice, a planner, and a partner who carries the patient's perspective.

I'd like to share the positive changes that are happening today in our health care system, but equally as important, I want to get out in front of what didn't work, because I believe that the LHINs have an opportunity to play a role in the continuous improvement of our system and finding patient-centred solutions.

Let me begin with my experience as a patient. Even though my job allows me to see the health system through a different lens than other Ontarians, I experienced the same feeling going into my surgery as many patients would. I had anxieties.

The first standout moment for me was during the pre-admission phase. I was extremely happy that all the tests required in advance were scheduled in one place and over one day. This experience was not unique to me. All the patients in pre-admit were treated the same, but that wasn't always the case. Previously, patients would have gone back and forth several times for tests, possibly to different locations, inconveniencing them and costing them in transportation and parking.

At the LHIN, we hear a lot about the gaps in patient care. They are the spaces between providers; for example, the time between the hospital visit and the visit to the family doctor after discharge. Best evidence suggests that those gaps in relationships make a difference to patient care.

I'll spare you the details, but the great news is that my surgery was a success. My discharge from hospital was another pivotal point for me. I just want to go back and say that the whole pre-admit was a major issue that the LHIN identified and had been working with hospitals on, because patients had said they were unhappy and it was in their patient satisfaction surveys. So there was a real push on from the LHIN for the hospitals to address this area of dissatisfaction.

My discharge from hospital was another pivotal moment for me as a patient. Prior to leaving, my medications were reviewed and I was told what not to take any longer and what the new medication requirements were. A home care assessment was also done so that I could leave the hospital feeling confident that I would be well supported in the community. Finally, I was given a paper copy of my discharge summary. The summary was a record of the reason for my admission, what happened in the hospital, all my medications, follow-up appointments, and instructions for my family doctor.

Up until a year ago, this summary would have taken months to reach family doctors. This gap meant that my family doctor would not know I had been hospitalized, what had happened to me, what changes had occurred and what was expected of her. Moreover, none of the community partners who were involved in my care would have had access to this information. I am happy to report to this committee that the summary I received is now a standard discharge plan.

The standardized discharge summary was a direct project of the Toronto Central LHIN. Our goal was to develop a consistent summary provided by hospitals to primary care providers and community support services. This emerged from a year's work we did with primary care. One of the issues primary care identified was not having this information, so we initiated that as a project.

This summary was developed with providers and clinicians at the table, and was designed to be easy to understand yet comprehensive. The summary provides all the information that clinicians say is critical for a safe hand-off from acute to primary care to community care.

Toronto Central LHIN brought our partners together throughout this collaborative process, and we were able to ensure buy-in and uptake, and increase implementation. Today, all 17 hospitals in the Toronto Central LHIN have begun implementing this summary in an effort to coordinate and improve medication reconciliation and follow-up instruction. This may seem like a minor change, but it gave me, the patient, the tool I needed to manage my own care. Each hospital in the Toronto Central LHIN is participating and spreading this practice across all divisions over the next two years.

I was absolutely thrilled to receive my summary. To be quite honest, the first email I sent to the office during my recovery was to let staff know that our hard work had paid off and the summary was a success.

This experience highlighted for me another change that should be on the radar of LHINs as we now talk about system change.

The LHIN is constantly scanning the environment to identify ways to improve the health outcomes of people at different stages of their journey throughout the health care system. We look for things that may not be on the radar of our health service providers because they don't fit easily into any one provider's area of responsibility.

In my experience, the only gap I felt when I left the hospital with my discharge summary in hand was something that would prepare me, on a very practical level, for the setting at home. For example, it would have been good if I'd had a resource that informed me of practical tips, such as preparing meals in advance, to help smooth out my transition to home. That would have been great. So I think there are still a lot of other things that we could do.

Let's move to my experience in my role as a caregiver and what I took away from that. So I'll introduce you to Barbara.

Barbara, like many seniors living in Toronto, is in need of care and wants to live independently in her own home. She is 83 years young, of Jamaican descent, and is a complex patient with visual impairment who suffers from dementia. But more importantly, Barbara was my mom's best friend, and she has no kids.

In 2008, I was asked to be her power of attorney for care, and I agreed to do that. Barbara took sick, was admitted to hospital and was discharged at just about the same time I was. We were both in the hospital at the same time and both discharged at about the same time. So we made quite a pair, with me as her power of attorney, me with a neck brace and immobile.

But she wasn't unusual. She's similar to a number of complex patients. She had visited her family physician, was admitted to acute care, and was then seen by the psychogeriatric team.

We were connected to the care coordinator in the hospital from the CCAC upon admission. We worked throughout that admission for a discharge plan. Upon discharge, we had one integrated plan that included occupational therapy, a home assessment, the family physician appointment, specialist referrals and appointments, community programming, transportation and medical equipment.

We started with a schedule for Barbara of getting seven days of in-home CCAC services and us providing the overnight. Since then, she has gone down to five days of in-home services and two days at an adult day program. We have started to plan what will happen as her dementia increases.

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As I went through Barbara's integrated care plan, I also recognized a number of the initiatives that were LHIN-driven and LHIN-funded initiatives.

The psychogeriatric outreach team out of Baycrest is a LHIN-funded program where Baycrest has responsibility for dementia and seniors with behavioural problems, and they now support long-term care and community care, using their expertise.

Integrated care plans are a big agenda for the Toronto Central LHIN, and we have funded that program specifically to improve the patient experience as they go across the hospital, to reduce the length of stay, and to reduce ALCs in hospital.

The enhanced adult day program: We did research and funded five enhanced programs across the LHIN for seniors such as Barbara to go to.

We also recognized that foot care was something that seniors needed, and those programs are now also offered out of the enhanced adult day program.

We have taken tremendous steps towards integrating care plans for our patients, but there are still gaps. One of the ones I found and observed is that we do not have in the system a streamlined assessment process. Every single provider was doing their own, different assessment, and they are not integrated. That is one of the failings I found, going through this myself, and that will be one of our next big tasks with the ministry.

The shift for me with the LHINs, and the questions that have come up, is that as a funder, not a direct provider, we bring together the various sectors. We don't have a vested interest beyond the improvement of assistance and outcomes for patients, and we can set goals and get everybody to work towards delivery of those common outcomes. That, for me, has been a key role of the LHIN, and certainly one that I have experienced.

There is a culture shift that needs to happen in our system, and I think the LHIN leadership is pivotal to making that happen. If nothing else, my personal experience has taught me to be grateful for what we have—Ontario's health care—and that it was there to serve me and Barbara.

These hearings—and even as we work on continuous quality improvement—sometimes have a way of diminishing the work that is actually being done well. It is easy to get bogged down in all the negativity, but in reality, if we get hung up, then we won't be able to create a better system for the future.

I think there is a lot of room for continuous improvement, and there is a lot of work to be done in that area. I think the LHINs can play a key role in making that agenda move forward by bringing the providers together, having common outcomes, and getting everybody to work together to deliver high-quality, cost-effective patient care.

I'm very comfortable and I'm here and I'm committed, as a LHIN CEO, to working for that delivery on behalf of patients as we go forward.

I wanted to thank you again for the opportunity to come before you, to make this presentation of my experience. I hope that I've given you a slightly different perspective of the role of the LHIN, because I've been able to see the impact of some of the programs directly on patient care. With that, I will stop.

The Vice-Chair (Mr. Ted Chudleigh): Thank you.

Mr. John O'Toole: There's the bell, Chair.

The Vice-Chair (Mr. Ted Chudleigh): There is a bell, and it's a 10-minute bell, I believe. We've got about two and a half minutes of questioning left, of which the government will take part. Then we will rise and recess and go to the vote.

Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Ms. Orridge, especially for putting the patient front and centre and for sharing your experience.

We had the association of CCACs in last week, and they talked a little bit about patient satisfaction surveys, not only in terms of the percentage who thought the care was excellent or good or whatever, which is not particularly interesting, but they also said that they are gathering ideas about things like gaps—as you described—in the patient experience.

Have you been receiving this type of information from the Toronto CCAC? How do you deal with this sort of information when it comes forward?

Ms. Camille Orridge: The OMA was here before. In this LHIN, we did an extensive bit of work with a lot of primary care physicians to find out what their needs were, what the gaps were for them to provide care. We have also worked extensively with the CCAC as to what is their experience in the gaps.

We've also gone out and done consultations with populations and with people and then pulled those pieces together. That has identified the priorities. It's out of that, for example, that the discharge summary became a priority because patients identified it; primary care doctors identified it. The hospitals didn't identify it, but they were the ones who produced it. The community agencies identified it.

We work with all of those providers together, but we start with, what are patients telling us that's not working? In most of the things that they identified, we were able to see that it's the hand-offs that were the problem. We have targeted that as some of our major initiatives.

Ms. Helena Jaczek: The discharge summary issue is big in the Central LHIN. So then my question is, how do you share your best practice or what you've heard in your LHIN with other LHINs? Do you share with the Ministry of Health? Where does it go from your desk?

Ms. Camille Orridge: Across all 14 LHINs, we do share. Again, just for information, we have one back office across all 14 LHINs: that one payroll, that one thing that's run by the Toronto Central. We have set up a system of one-out-the-door, perfected and spread. A lot of times, people say, "You're not consistent." A lot of it is deliberately not consistent. South West and Toronto Central first did the work on primary care, and spread.

We have done the work around the discharge planning. We've shared it with the ministry and we are now sharing it with the other LHINs. That's how we test-spread.

Ms. Helena Jaczek: Anything else—

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We appreciate it, and thank you very much for coming back to the committee.

Ms. Camille Orridge: Thank you.

The Vice-Chair (Mr. Ted Chudleigh): The committee will now recess until the vote. When we come back, we will be in closed session, with MPPs and legislative staff only. Thank you very much.

The committee recessed at 1557 and continued in closed session at 1614.

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SP-40 SP-40

ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40e législature

Official Report of Debates (Hansard)

Monday 31 March 2014

Journal des débats (Hansard)

Lundi 31 mars 2014

Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur l'intégration du système de santé local

Chair: Ernie Hardeman
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Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

Monday 31 March 2014

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Lundi 31 mars 2014

The committee met at 1400 in committee room 1.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW
ÉTUDE DE LA LOI SUR L'INTÉGRATION DU SYSTÈME DE SANTÉ LOCAL

The Chair (Mr. Ernie Hardeman): I call to order the meeting of the Standing Committee on Social Policy. We are here today to hear public delegations on the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act.

ONTARIO HOSPITAL ASSOCIATION

The Chair (Mr. Ernie Hardeman): Our first delegation is the Ontario Hospital Association, and we welcome them here this afternoon: Anthony Dale, president and chief executive officer; Elizabeth Carlton, interim vice-president, policy and public affairs; and Andrée Robichaud, president and chief executive officer, Thunder Bay Regional Health Sciences Centre and Ontario Hospital Association (OHA) board member. We want to welcome you all here.

For your presentation this afternoon, you will have half an hour. You can use any or all of that. After that, we will have a half an hour opportunity for each caucus to address any questions to you as they relate to your presentation, or to make comments for the committee's purposes. With that, the time will start now, and you'll have half an hour to make your presentation. Any one of you can speak, as you see fit.

Mr. Anthony Dale: Thank you very much, Chair, and good afternoon. Thanks so much for having us here today.

As the Chair mentioned, my name is Anthony Dale, and I am president and CEO of the Ontario Hospital Association. Just for your background, the OHA is a voluntary organization which represents the 149 public hospitals that operate across approximately 225 sites in the province of Ontario.

On behalf of our members, I am very pleased to be presenting today and sharing the experiences and perspectives of Ontario's hospitals as they relate to the strengths and opportunities for our work with Ontario's local health integration networks.

Today I have the good fortune of being joined by one of our member representatives, Andrée Robichaud. Andrée is the president and CEO of Thunder Bay Regional Health Sciences Centre, a member of the OHA board of directors and the chair of a special committee convened by our board to guide the OHA's work in preparing for the review of the LHSIA. Beside me, as the Chair mentioned, is Elizabeth Carlton, our vice-president, policy and public affairs. Behind us, just for your information, are several other members of the OHA staff, who are here to help with some technical questions if you have any.

To begin, I'd like to give you a bit of background on our organization and its members. As the voice of Ontario's hospitals, the OHA strives to achieve a high-performing health system for Ontarians by fostering leadership, supporting innovation and building linkages between hospitals and their communities.

As I'm sure you can appreciate, Ontario's hospitals are as diverse as this province, and so our members represent a broad range of hospital types. They include community, acute care, small hospitals, complex continuing care and rehabilitation facilities, pediatric hospitals, mental health and addictions centres, and internationally ranked academic hospitals with associated research centres.

Together, Ontario's hospitals employ over 200,000 people and serve thousands of Ontarians every day. In 2012-13, Ontario hospitals performed 350,000 in-patient surgeries, over 1.1 million outpatient surgeries, and responded to over 5.9 million emergency room visits. In total, there were 20 million patient visits in Ontario's hospitals last year.

We're extremely proud of our province's hospitals and the work they do every day to ensure that Ontarians have access to high-quality care. We're also proud of our hospitals' impressive track record in demonstrating leadership, innovation and collaboration to bring better care to patients and clients and bring greater efficiencies to people.

For years, Ontario's hospital leaders have recognized the need to collaborate and partner with other care providers in order to continually improve efficiencies, access to care and overall quality. Because of this good work, Ontarians are hospitalized less frequently than anywhere else in Canada, and Ontario has the lowest rate of age-sex standardized acute care hospitalization at just 7,038 hospitalizations per 100,000 people.

All of these successes have worked together to produce an efficiency dividend for the province that in 2013 totalled $3.6 billion. That's $3.6 billion that can be better spent on other pressing health system priority areas.

These successes have not been achieved in isolation; on the contrary, they are a direct reflection of Ontario hospitals' many positive relationships and partnerships with other health leaders in the delivery of care and in its planning.

Since the introduction of LHINs, there has been marked and concentrated effort at the local levels across the province to further improve accountability and health system performance. That focus remains, and we believe that every leader in today's health system has a strong interest in continuing to work together to bring even better care to people and the communities we serve.

It's in that spirit of pursuing ongoing progressive collaboration that the OHA participates in today's discussion. We see the LHSIA review as an opportunity to engage stakeholders and evaluate an important piece of legislation to determine whether there are barriers to effective health care service delivery in Ontario.

For our part, we have undertaken a robust member engagement process to ensure that we have an accurate understanding of our members' experiences with LHINs and to inform our recommendations.

As the chair of our board's special committee that guided the OHA's work related to the LHSIA review, Andrée is ideally suited to describe our approach and our motivation for the recommendations we are presenting to you today, so I'll now turn it over to her for a brief description of how we arrived at our recommendations.

Ms. Andrée Robichaud: Thank you, Anthony, and good afternoon to the committee members. Merci, Anthony, et bonjour aux membres du comité.

Comme présidente et directrice générale d'un hôpital, je peux vous dire que les hôpitaux attendaient une révision de cette loi avec anticipation. As the president and CEO of a hospital, I can speak to the keen anticipation hospitals have had in expecting a review of the LHSIA.

J'aimerais aussi souligner que l'engagement de ses membres est une fonction primaire de notre association. I can also highlight that robust member engagement is a primary function of the OHA.

C'est avec ces deux intérêts que le conseil de l'OHA a convoqué, dans un premier temps, un groupe de travail en 2012 pour commencer une révision préliminaire des relations entre les hôpitaux et les « LHIN » et comment cette loi impacte leur travail collectif. It was in these two interests that the OHA board of directors convened an early working group back in 2012 to begin an initial examination of hospitals' relationships with their LHINs and how the LHSIA impacts their collective work.

Le travail de ce groupe a suscité de très bonnes discussions, mais aucune recommandation ne fut développée, étant donné l'absence d'une révision formelle de cette loi. The work of that group afforded some good discussion, but no formal recommendations were made in the absence of a recognized LHSIA review process.

En novembre dernier, lorsque la révision de la loi fut annoncée, le conseil de l'OHA créa un comité en bonne et due forme dont j'ai eu le privilège de présider. Then this past November, when the LHSIA review process was announced, the OHA board of directors formally convened a special committee of its members, a committee that I had the distinction of chairing.

The OHA special committee for the LHSIA review built on the work of the previous working group but with a more formal mandate. That mandate was to consider options for responding to the activities related to the LHSIA review and to provide direction to the OHA.

I should also add that the committee's membership included hospital CEOs from each of the 14 LHINs.

As a committee, we shared our experience working with LHINs and our other health system partners and began to explore ways that we could be doing even more together. In all of our discussions, a consensus was often found in the common appreciation for the made-in-Ontario model of integration that the government chose to implement nearly a decade ago.

Hospitals see LHINs as a valuable regional body that can facilitate local planning, understand and address local issues, and help enhance health system performance. These are strengths of the LHIN that Ontario hospitals support.

We found consensus in our appreciation of and value for the added accountability that LHINs have helped us achieve. So, in preparing for the OHA's submission to this committee, we started asking ourselves how we could, as a health system, build on the progress that has been made to date. How could we establish even more accountability? How else could we drive change and advance integration? What could we be doing to better serve our communities?

We looked at the legislation also, and there are a few areas where we noted that the legislation itself could be made stronger. We will touch on those a little later in our presentation.

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But the bulk of our work focused on the prime opportunity that the LHSIA review presents to put additional measures in place that we believe could really accelerate and enhance our work in supporting local health system improvements. Our committee supported the OHA in putting these ideas to paper. We have presented our ideas and recommendations to all of the OHA's hospital members for their review and feedback, which has been incorporated in the submission before you.

My colleagues and I believe that the citizens of Ontario want and deserve coordinated action to improve their health care system. They want hospitals, LHINs, the Ontario government and everyone in the health system working together toward the common goal of ensuring great patient care. We know that asking questions about

what works well in our health system and what can be improved is always an important discussion to have.

Our committee has done a good job of guiding the OHA work in preparing for the LHSIA review, and we're very pleased to share with you such thorough insight from the province's hospitals. I will now turn it back to the association to share our findings and recommendations.

Mr. Anthony Dale: Thanks, Andrée.

It's true that Ontario's hospitals see great value in the important role LHINs play in planning and supporting accountability and other performance efforts. It's also true that the LHSIA itself is a strong piece of legislation, particularly because it centres on improving the interconnectivity of health services, allowing for local creativity and innovation, enabling equitable access to health services, encouraging and requiring community engagement, and supporting evidence-based practices and programs. It provides LHINs with a clear legislative mandate and a strong foundation of authority.

Since the introduction of LHINs, we have seen health system accountability grow and mature. We recognize how accountability to our LHINs and to our communities has helped enhance overall health system performance. For instance, thanks to LHIN-hospital accountability agreements, there are much clearer two-way expectations respecting hospital-based performance outcomes than there were 10 years ago. And we have seen how a provincial, local and regional focus and integration have helped target our efforts on key health system challenges, particularly alternate level of care, or ALC, patients.

ALC patients are people who have received their full episode of care in a hospital and are waiting for discharge to another, more appropriate setting. Now, it's certainly not uniform across the province, and there is still a lot more work to do. But by working closely together, providers, LHINs and the Ministry of Health have been able to reduce the number of ALC patients in Ontario's hospitals from a provincial high of 20% just a few years ago to less than 14% today.

Today's LHSIA review represents an opportunity to advance the discussion about what else can be done to make the health system work better to serve these patients and clients. From our vantage point, there are two helpful ways we can do this. The first is by strengthening our understanding of roles and responsibilities, and the second is to establish a long-term strategic plan with explicit performance metrics for the system.

Let's start with roles and responsibilities. Let me say that, in our experience, all health system partners share a strong commitment to advancing a high-performing system. Certainly, the OHA and all of Ontario's hospitals enjoy a very strong relationship with the LHINs. Our responsibility today is transforming our shared commitment into a common course of action.

In 2008, when KPMG reviewed and reported on the effectiveness of the LHINs, it was noted that a clearer understanding of the respective roles and responsibilities of the Ministry of Health and Long-Term Care and LHINs was needed in order to advance health system integration. The Ministry-LHIN Effectiveness Review signalled the existence of "authority grey areas," where it was unclear what aspects of authority and decision-making rested with the LHINs and what authority the ministry retained. Additionally, in Don Drummond's 2012 review of public services, a number of similar issues were noted.

Both the KPMG review and the Drummond report allude to the need for clarity over these respective roles. We do believe that more work needs to be done to define and sharpen the roles and responsibilities of the ministry and LHINs in order to strengthen health system planning, funding and organization, ultimately for the objective of improving quality of care for people.

The goal of the act is to enable LHINs to make local decisions about program funding, with the ministry determining broader health system policy and goals, establishing criteria for funding allocation, and engaging in capacity planning. But in practice, this has proven far more complex to do than it might seem on the surface. For instance, some areas of health care funding remain centralized—the pricing of quality-based procedures is a good example. Other decisions, such as determining allocations from the Seniors Strategy, reside at the LHIN level. This intermingled approach to decision-making and the setting of provincial and community-based priorities associated with it needs to be better aligned and integrated.

When it comes to making decisions about the way in which health services are delivered, more work needs to be done to calibrate the parameters of decision-making at the LHIN level. Let us ask: In what areas should LHINs have clear and unambiguous authority to make decisions, and in what areas is there an overarching provincial policy consideration that needs to be taken into account? When thinking about the planning reconfiguration of health services, are there minimum access standards that should be established to guide decisions? In our view, as health system funding reform accelerates, and LHINs and hospitals and then other providers start to make long-term decisions about changes in service delivery, this question will become even more significant.

The LHSIA review presents an ideal opportunity to strengthen the ministry-LHIN and inter-LHIN collaboration frameworks and address these authority grey zones. It's also an opportunity to explore the question of whether or not policy standards and benchmarks are needed in areas where there is an intermingling of ministry and LHIN roles.

Over two years ago, the Ministry of Health and Long-Term Care released its action plan for health care. The action plan spells out the government's three main areas of priority and describes the activities and initiatives under way to make progress in each one. The objective, which is a commendable one, is to transform the system to make it better for patients. Given the extraordinary fiscal challenges facing Ontario, it is essential to change the way health services are delivered.

Ontario's hospitals are playing a leadership role in system transformation. For instance, hospitals are accelerating their efforts to implement health system funding reform in order to further improve quality of care for patients and drive greater value. They have not received a funding increase in two years, and we fully expect that in the upcoming budget, there will again be no increase in spending on hospitals.

Now, while challenging, we understand why this is necessary. It is part of a strategic effort to expand funding and capacity elsewhere in the system, particularly in the community. That's why, as part of the OHA strategic plan, we track expenditures in the community setting as a vitally important metric.

In the lead-up to the balanced-budget target year of 2017-18, at the very time hospitals and other providers are implementing very large-scale change initiatives, the system will also come under intense pressure. Service demands will continue to grow across the board at the very same time that the system will come under very considerable compression as it moves to contain further cost growth. At this pivotal juncture, we believe it is essential to establish a long-term strategic plan for the system.

The government of Ontario should set and communicate specific medium- and long-term goals for the system, with specific, quantifiable performance targets, so that health care providers can effectively contribute to their achievement and the public can understand where our health system is headed and why.

The truth of the matter is that today, hospitals and other health providers are grappling with hundreds of indicators and other performance metrics. Examples include but are not limited to quality improvement plans, accountability agreements, patient safety indicators, Cancer Care Ontario, the Canadian Institute for Health Information reporting project, Accreditation Canada, the Cardiac Care Network of Ontario and Ontario Stroke Network programs, and audits, to name just a few.

Often, these indicators and reporting mechanisms are not in alignment, which is cumbersome from an accountability and compliance perspective. There has been some positive movement to address these concerns in recent months, but what the issue still powerfully demonstrates is that we don't yet have clear our long-term system goals and objectives.

A crucial component of this long-term strategic plan must be health system capacity planning. Capacity planning is a crucial component to guiding the health system's focus. It includes activities such as forecasting and benchmarking the number of different types of beds or services in hospitals or long-term care, and the number of assisted living spaces, home care hours, primary care services and mental health services, to name a few. All this is needed to meet the needs of different populations into the future.

A comprehensive capacity plan would drive sound decision-making regarding where care should be provided, who should provide it and how it should funded. We need to develop a provincial and regional mechanism for forecasting the necessary breadth and mix of services across the different health care sectors.

The health care system, I don't have to tell you, is highly interdependent. In 2006, when an almost-decade-long expansion of long-term care wound down, the number of ALC patients in hospitals suddenly began to increase, and it did so with extraordinary speed. That is how interdependent our health system is, and that's why we need to be making deliberate, informed choices about where to maximize health system capacity outside of hospitals, particularly in the lead-up to the province's balanced budget target.

We cannot afford to lose our grip on the gains that we are making in changing the system to better meet the needs of our patients and clients. Building on the recommendations of other organizations that I know have appeared before you, the OHA and its member hospitals encourage the committee to consider the development of a long-term provincial plan, supported by capacity planning, as one of your recommendations.

These are our core recommendations for the committee to consider. We also have a number of targeted recommendations specific to LHSIA itself that we believe can help strengthen the legislation. I'm going to ask Elizabeth to speak to each of these in a bit more detail.

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Ms. Elizabeth Carlton: Thank you, Anthony. Continuing on the theme of supporting Ontario's LHINs and achieving the full extent of their mandate and the needs of Ontario's health care system, we would like to offer a few additional considerations specific to the act itself that we believe would help enhance the legislation and the work that it governs. Our written submission outlines a few recommendations for amendments to LHSIA, but there are just two specific ones which we would like to highlight for you today.

The first relates to strengthening LHIN governance. Ensuring that LHIN boards are representative of the communities they serve is an important feature of LHIN governance. Drawing LHIN board members from local communities not only makes LHINs more accountable to the regions they serve but also fosters creativity and innovation.

There are good governance practices in health care that serve the health system very well, and we believe we could apply those to the strengths of LHINs. For example, delegating board recruitment and selection activities directly to the LHINs would help ensure that their governance structures are best suited to promote long-term board stewardship and stability and that recruitment efforts reflect the best possible skill-competency mixes for individual organizations and communities. Moving in this direction would help keep LHIN governance consistent with widely accepted good governance practices. It would also align LHIN governance with the well-respected tradition of voluntary governance that is present in most other areas of Ontario's health care system.

We also wish to point out that section 27 of the act requires LHINs and health service providers to wait a total of 60 days before proceeding with even voluntary integrations. Now, while we appreciate that this provides the opportunity for LHINs to review and respond to voluntary integration proposals, there is currently no mechanism in the legislation that would allow the LHINs to waive this period, even when they support such a move and see no need to wait the 60 days. We believe that amending LHSIA to provide LHINs with the discretion in limited circumstances to waive the notice period for voluntary integration would help eliminate unnecessary delays and help accelerate positive integrations at appropriate times.

As I have mentioned, we have other suggested amendments to the act outlined in our submission, but it is these two which we believe best complement our core recommendations that Anthony described earlier.

I will look forward to your questions but will turn it back to Anthony for some closing remarks.

Mr. Anthony Dale: Once again, I'd like to thank the committee for your time today. I'll close our presentation by saying that the health system transformation currently under way in Ontario is a significant step forward in changing the system for people for the better.

We have seen through our experiences with the LHINs that collaboration and partnership are key ingredients to building a better, more efficient and more integrated system. Like all Ontarians, we wish to see this momentum for high performance continue to build, so we are pleased that this review of the LHSIA is taking place and that we've had the opportunity to participate.

So thank you, and we look forward to the discussion here today.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We will now have half an hour for each caucus, and we will start with the government side for the half-hour. You do not have to use it all at once if you wish to just rotate, and we'll just keep rotating until everyone's time has been consumed.

With that, Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Chair. And thank you for coming in and for all the consultation that you have undertaken with your members.

I guess I'll start with some of your suggestions, first of all those that do not require legislative change. I must say, I'm a little bit confused. You're calling for a provincial strategic plan for health care. I think, as we all know, the Ministry of Health and Long-Term Care is undertaking a transformation of health care, the action plan for health care, which is clearly to put less reliance on acute care and hospitals and much more of an emphasis on community. And then you've also alluded to a whole lot of benchmarks and indicators that are kind of out there.

I would have thought that the government's intention was fairly clear, but you're pointing to the need for something else. So could you articulate, tell me more about, what you mean by "a provincial strategic plan"?

Mr. Anthony Dale: Sure. As I said in our opening comments, we do strongly support the government's action plan and its various components. There is ample proof that the OHA and the hospitals are fully committed to its implementation.

I guess what we're also saying, though, is that from the point of view of an individual hospital, that has to sometimes juggle literally hundreds of performance indicators that are embedded in everything from a hospital service agreement that it has with its LHIN to a quality improvement plan that it has with its board and is submitted to the provincial government to other indicators of performance that come at it from external bodies, some of them with regulatory authority—if you're an individual hospital, it can be very difficult to deal with such a diffusion of focus, because everybody's indicator is important.

What we're saying is, let's work to create a long-term plan, building on the action plan, that sets apart the most important system performance metrics that all providers should concentrate on, and make sure that we have built the pathway very clearly to achieving it. That's it, in a nutshell.

Ms. Helena Jaczek: You're saying, then, that those particular, most important areas of focus would be reported to the provincial ministry.

Mr. Anthony Dale: They would, in fact, set them. If you note, in the LHSIA review is the requirement that the province establish a provincial plan for health care and that it table it each year in the Legislature. Obviously, the ministry is using the action plan as its way of being held to account for this particular requirement.

All we're saying is to concentrate on the long term, concentrate on articulating those long-term, strategic objectives, and that we should be even more definitive about the pathways we're choosing to use to achieve them.

Ms. Helena Jaczek: In other words, just to make it really clear—because we're all very concrete people here, and buzzwords get a little complicated—what you're basically saying is that there would be indicators that would be reported on, consistently, from every hospital, presumably to the LHIN as well as centrally to the ministry. Am I understanding that?

Mr. Anthony Dale: It's a little bit tighter than that. It means, at a system level, what are the primary system changes that the government wants to achieve over the long term—and articulate the benchmark objectives that you would like the system to achieve.

I have in my hands here, for instance, the indicators that are part of the Health Quality Ontario common quality agenda, the indicators that go into the hospitals' performance agreements with LHINs. In the hospital performance agreements with LHINs alone, there are 33 separate indicators. With the common quality agenda, there are another 23. If we look at the new performance indicators being designed for the clinical handbooks that are associated with quality-based procedures, there are another 125. That's just one package alone. That's a

cumulative number of well over 200 indicators. All of it is important. All of it, at the micro level, is pushing and driving change in those clinical areas and more systematic areas.

From the hospital point of view, we're just talking about helping to sharpen our understanding of where the focus needs to be overall for hospitals, just being a bit more specific over the long term about exactly what you'd like the hospitals to achieve within that wider system.

Ms. Helena Jaczek: Okay. As you know, we've heard from many deputants. We've been all over the province and heard interesting submissions. The LHINs themselves are advocating that they expand their sphere of responsibility to include primary care and public health. Obviously, you have physicians on staff at your hospitals. You liaise with public health. Do you have any opinions on that?

Ms. Andrée Robichaud: I think primary care is—first of all, what is primary care? When you look at the definition of primary care, you look at first contact. It's bigger than your family health teams; it's bigger than the physicians. It does include public health. One size doesn't fit all.

I think the government really needs to look at, in terms of primary care, what a framework is. In a very rural area, as you would know, a lot of the family docs keep the hospital going. In other areas, our family practitioners don't work in the hospital. So there needs to be a really good framework, a robust framework, when you look at primary care before you ever move to where that governance should be. I think, from a primary care position, we really need to look at: How do we want it to work and how should it work? And then add a third question: How do we then organize it, and where, from a government perspective, should it lie?

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Ms. Helena Jaczek: Would you, then, as a summary, say it might be premature to—

Ms. Andrée Robichaud: I would think so, yes.

Ms. Helena Jaczek: Okay. Thank you.

In terms of your engagement with the hospital, as an organization, as the Ontario Hospital Association, do you have any liaison centrally with the—I forget what the LHINs call it, but they have a leadership council or something. Do you have a relationship at that level to try and talk about consistency across the 14 LHINs?

Mr. Anthony Dale: Sure. There are certain formal relationships we have with the LHINs. The OHA is a member of the LHINs' System Strategy Council, which meets quarterly. At that venue, which I've just started to attend in the last year, there is discussion about the kinds of issues that we're describing to you, mostly related to the long term.

At the meeting held most recently, capacity planning was absolutely the topic of the day. I understand that at the next meeting, the different provider associations, along with the LHIN leadership there, are going to be discussing very tangibly what information we know about capacity planning that exists today in the health care system and what we can do to bring it all together and partner with the provincial government and move forward with this critical function.

Probably the most important direct relationship the OHA has with the LHINs is through a joint committee that deals with the hospital service accountability agreement and the associated performance metrics, the ones I described here. That template agreement was negotiated jointly several years ago between the OHA and the LHINs, and it's certainly a timeless document. It has stood the test of time rather well.

That committee is very much intended to support both LHINs and hospitals with the annual cycle of accountability. There are a host of resources that we provide to do that. There are joint webcasts and telecasts with joint work projects around working through some of the performance indicator questions. I know you'll be aware, Helena, that it's very, very complex stuff, but that's a very specific example of the kind of direct relationship the OHA has with LHINs.

Ms. Helena Jaczek: Okay. So let's first talk about that template agreement. Obviously, you've brought the issue of this plethora of indicators to that table, and presumably have advocated for some sort of streamlining.

Mr. Anthony Dale: You're right. That's why I said in the comments we made at the beginning that there is progress being made. It's just that if we step back and we think about the challenges ahead of us over the next three to five years, we just can't get that focus quick enough, is all I was trying to say.

Between the ministry and the LHINs and the OHA and—

Interjection.

Mr. Anthony Dale: —HQO; thanks, Elizabeth—there is a lot of work going on right now to try and arrive at what the overarching system indicators should be. And then we need to literally align these legally binding, highly complex compliance documents together so that they're fully integrated. Otherwise, you've got one set of performance requirements driving you in one way and another set driving you in another. So we just want to make sure they're in much greater alignment and integration.

Ms. Helena Jaczek: Okay. Well, that's very helpful when we go back to your comment regarding the provincial strategic plan, because I feel fairly confident that from the point of view of the ministry, they would say, "Well, what are your proposals? You're the guys on the ground who know it, so please come with that streamlined kind of, what you believe"—given the action plan, given the transformation—

Mr. Anthony Dale: We're not the kind of organization to sit back and tell everyone else what to do. We've got our sleeves rolled up and we're working very closely with all the other partners to try and accomplish the very things we've articulated. This committee and this review asked us to speak about the kinds of things that we think are most important, so it was in that spirit that we made that—

Ms. Helena Jaczek: So it's a process of accelerating, perhaps, encouraging, making sure that it actually happens, is where you're coming—

Mr. Anthony Dale: Yes.

Ms. Helena Jaczek: Okay, that's helpful.

Capacity planning: We heard quite a bit from the various LHINs and from the CCACs, as a matter of fact, in that, of course, many of us have ridings with more than one LHIN. One of our members has four LHINs, four CCACs, and they see a difference in the level of service that is provided, particularly when it comes to a community care access centre. It's often explained to this committee that the differences are because of a lack of capacity, either of personnel or resources in some fashion.

Can you just talk to me a little bit more about how you see that capacity plan being developed, or who would be the key players here? How should this be organized, this capacity plan across the board?

Mr. Anthony Dale: Yes. You're asking a very complex question, and we won't pretend to be able to answer it as precisely as perhaps you'd like us to. But in one earlier point in the province's history, when it came to health system planning through the Health Services Restructuring Commission, there was a deep database of information and a methodological approach to thinking about, based on population health needs, exactly what level and amount of service would be required in a specific community into the future—five years, 10 years down the road. I'm not saying the commission was perfect, because it wasn't, but it was that future look that people often forget was actually the other half of its mandate.

All we're saying is, we need to use that same basic approach—looking at data, information about population health need in a local community, in a region and even at the provincial level—and forecast with real precision what the future capacity needs are going to be. From our point of view, the most significant areas requiring that attention are community services and long-term care, because we know from the evidence reported in the government's access-to-care reports that these are some of the most heavily cited kinds of services required by people waiting for discharge from hospital.

We know anecdotally that that is absolutely what the evidence suggests, but we don't yet know exactly what that means next year, the year after that, five years after that, 10 years after that, and that gets back to the heart of our submission. As we move up to that balanced budget target and we keep that compression on hospitals to transform the system, we have to make sure you've got capacity—especially in home care and long-term care, assisted living, palliative care and so on outside of that hospital setting—to catch those patients and give them the care they need with a minimum of wait, if any.

That's a complex challenge, but if the ministry and the provider community apply themselves, I'm confident we can get the right methodological approach. What comes next are the hard decisions to build out that capacity into the future and meet that future need.

Ms. Helena Jaczek: What about the capacity of hospitals? You focused your comments on the community sector. How do you look at your own capacity?

Mr. Anthony Dale: Great question.

Ms. Helena Jaczek: Do you do bed projections, ER, staffing projections, need for ophthalmologists? How do you work—

Mr. Anthony Dale: Well, there is a lot of service capacity planning in hospitals today, and that's done with the ministry. For a lot of the very high-cost, specialized services, there's already a foundation behind them for service planning.

But the question you're asking is a very good one because if you look at the numbers, since 1998, the number of hospital beds in the province has stayed roughly at the same amount: about 31,000 beds. Over the same time, almost two million people have joined the province and so that, combined with some of the other performance metrics I've described to you about the length of stay being very, very low, admission rates being very, very low, per capita spending being the second-lowest now in the country, points to a system that is pretty efficient. But we know, given the sheer size of the hospital budget—it's almost $23 billion, if you include the hospitals' own revenues—there's a lot of room for improvement within the hospital itself. That's why we're so invested in the transformation agenda. Quality-based procedures and other dimensions of funding reform hold a lot of promise at achieving greater quality and value within the hospital setting itself.

Thinking about future capacity within the hospital is a fundamental piece of that transformation, and that's the kind of direct connection of the hospital into that wider process.

Ms. Helena Jaczek: And you're engaged very actively in that in terms of your—

Mr. Anthony Dale: We have a very strong partnership with the ministry, the senior ministry officials. I think we would all agree that we all have a lot of work to do over the next many years to strengthen the health system funding reform, but it is a very strong collaboration and it's getting better every day.

Ms. Helena Jaczek: Just turning to one of my pet peeves in the GTA, which is boundaries, the original ICES report—as our researcher has looked back and seen, in 1996, originally there were seven regions that the province proposed, basically around tertiary care facilities, to ensure that there was that strength in each planning area.

Has it been an issue for any of your member hospitals, in terms of communication? We've heard stories about the electronic health records and everything being wrapped around the patient and everything being seamless. But from the practical point of view of my constituency office, it's not seamless.

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Mr. Anthony Dale: No.

Ms. Helena Jaczek: You can hear my bias. But from the point of view of individual hospitals—the sort of

infamous Markham Stouffville Hospital having their satellite in Uxbridge in a different LHIN, etc.—is this an issue, or have you been working around it? Do you see any opportunity for change?

Mr. Anthony Dale: To be honest, we take your guidance on it. It's not something we hear about frequently at the OHA. The few occasions when it has come up have to do with someone within a hospital not really quite knowing precisely what the rules are or the policy framework around LHINs, so they might wrongly say, "Sorry, I can't serve you here because you're from another area." But those are very few and far between.

But we would take your guidance. If there's more there than meets the eye, we would like to hear about it.

Ms. Helena Jaczek: So you're essentially neutral on that subject?

Mr. Anthony Dale: Well, no. We take your guidance on it. If there's something there, then we'd like to hear about it.

Ms. Helena Jaczek: Okay. Thank you. We'll probably reserve our time, whatever is left. What is left?

The Chair (Mr. Ernie Hardeman): Okay, thank you very much. We'll go to the official opposition. Who has a question? Mr. Holyday?

Mr. Douglas C. Holyday: I could start. I noticed you referred us to an efficiency dividend of $3.6 billion in 2013. Can you explain that, please?

Mr. Anthony Dale: Sure. It's illustrative, but what it is, is that if you look at per capita spending in hospitals in each province across the country, if Ontario's hospitals were funded at the national average, you'd have to spend $3.6 billion more just to move up to that level.

To us, it's an important way of demonstrating just how efficient the system is. So, if you just compare that to other provinces, it says we're spending a heck of a lot less per capita in Ontario, and that allows more resources to be freed up for other priorities. In our view, that's a critical thing to do—in particular, community and long-term care and assisted living.

Mr. Douglas C. Holyday: What provinces would be in the higher end of the scale?

Mr. Anthony Dale: Alberta. Alberta spends the most per capita in the entire country, by a vast, vast amount.

Mr. Douglas C. Holyday: What would the reason for that be?

Mr. Anthony Dale: I don't know.

Mr. Douglas C. Holyday: Would they be inefficient?

Mr. Anthony Dale: We're talking about per capita expenditures, and from our point of view it suggests that Ontario is relatively more efficient than Alberta. If you look at some of the political debate that has occurred in Alberta over the past couple of years, that theme has been prevalent in that province: "If other provinces spend less per capita than we do, why can't we lower our expenditures and become more efficient?" Again, the whole purpose of this is to free up resources for other priorities.

Mr. Douglas C. Holyday: Okay. I have to think about that one.

Mr. Anthony Dale: Sure.

Mr. Douglas C. Holyday: I notice here that you're making a recommendation to get away from government-appointed LHIN boards. I just wonder what your reason was for that and how you arrived at it.

Ms. Elizabeth Carlton: When the legislation was first introduced, it was something we addressed in our submissions at that time, and our position has remained unchanged since then. The reason is that, traditionally, best practice in good governance is to have voluntary, community-appointed boards. Traditionally, it has been found that they're selected on a competency, skills-based model, they represent the community and there's no kind of financial incentive. That's really how you get the best people.

I think we've done a lot at the OHA, in terms of our work on good governance—the Governance Centre of Excellence—and I can tell you that we have over 2,000 volunteer board members within the system. The selection process that we have promoted through our Guide to Good Governance and other materials has been sort of a competency model selected through the community in a very transparent manner. Of course, the hospital sector is a voluntary, sort of, non-remunerative model, and there has been no shortage of applicants, so it tends to yield the best candidate as opposed to just having people appointed.

Mr. Anthony Dale: I think another dimension to that is that the board itself becomes responsible for its long-term stewardship, not someone else. That, as I'm sure you're aware, is a key dimension to good governance, that the board itself takes responsibility for recruitment and retention of board members and builds up the resources and supports around them. That's what we're saying: Let's make sure that that happens at the local level into the future.

Mr. Douglas C. Holyday: So instead of the government appointing people to sit on these boards, the board itself would run the competition—

Ms. Elizabeth Carlton: Yes.

Mr. Douglas C. Holyday: —and seek people who have the qualifications, and the interest, I guess, in the local areas themselves, perhaps even through the hospital communities, to strengthen the boards.

Mr. Anthony Dale: Well, it certainly wouldn't have to be through the hospitals. It should be through the LHINs themselves. We know that there is the ability of people to apply for OIC appointments as a LHIN board member, and there are absolutely processes in place. What we're saying is, place it in the hands of the LHIN or give the LHINs a body to accept full responsibility for that recruitment and retention function—I think there's precedence in the college sector for that kind of role—and then make recommendations to the province for that appointment. There's different ways to look at it, but the key is to patriate that responsibility at the LHIN level.

Ms. Elizabeth Carlton: But just to add to that, I think what we've found in the hospital sector is that ownership that the board has over their processes, the strength of community representation, is a fundamental component

of the governance practice. It's a great strength that the hospital can point to, and the community feels that they generally have a voice.

Mr. Douglas C. Holyday: Well, I notice also that you're recommending that these people not be paid. That's probably fine with me, too, but I just wonder: How much are they getting paid now?

Ms. Elizabeth Carlton: Currently, the board chair is paid $350 per diem, and individual board members $200 per diem.

Mr. Douglas C. Holyday: I'm sorry, that was $250—

Ms. Lisa M. Thompson: It's $350.

Mr. Douglas C. Holyday: It's $350 for the chair. And how much for the members?

Ms. Elizabeth Carlton: It's $200 for board members, per diem.

Mr. Douglas C. Holyday: How many times would they meet?

Ms. Elizabeth Carlton: I don't have those facts at my fingertips, but you can expect that they may—

Mr. Douglas C. Holyday: Well, would it be monthly or weekly, or would some of these people be out every day?

Mr. Anthony Dale: I'm sure it would depend on the LHIN and it would depend on the organization. But I think what we're really trying to say to you is that there's a long tradition of volunteerism in health care governance. We're saying: Let's make it consistent.

Mr. Douglas C. Holyday: I'm just wondering—I've had people from the LHINs call on me over the years, explaining what they were doing and so on, and three or four of them would come. Would they be on the per diem for doing a thing like that?

Ms. Elizabeth Carlton: I think that's something you would probably have to ask them. I know that there's probably some guidance around when they can charge the per diem, but we're probably not best suited to answer that.

Mr. Anthony Dale: Again, it's the tradition of volunteerism in health care governance that we're driving at here, not how much they made or may not—

Mr. Douglas C. Holyday: Like the hospital boards themselves.

Mr. Anthony Dale: Pardon?

Mr. Douglas C. Holyday: The hospital boards themselves. The people who are on the hospital boards for the most part are volunteers, are they not?

Mr. Anthony Dale: No, they're all volunteers.

Mr. Douglas C. Holyday: They're volunteers, and they're not paid?

Ms. Elizabeth Carlton: They're not paid.

Mr. Anthony Dale: Most if not all of all of their health provider organization boards are unpaid.

Mr. Douglas C. Holyday: Okay, thank you very much. That's all for me.

The Chair (Mr. Ernie Hardeman): Ms. Thompson.

Ms. Lisa M. Thompson: I'm noticing in your package that you prepared for us today that a lot of your recommendations point to the fact that there has been strife, if you will, because the relationship between the ministry and the LHINs had not been clarified. And I can appreciate that. You specifically point to the Drummond report. If I can quote your package here:

"The Drummond report recommended clarity of roles and responsibilities at the strategic, local and provider levels to stabilize the health policy-making and funding environments in order to help all parties manage routine and new initiatives more smoothly, create a better patient experience and increase public confidence in Ontario's health care system." Then you go on to say, "We fully support this recommendation."

My questions are around that, okay?

Mr. Anthony Dale: Sure.

Ms. Lisa M. Thompson: When you say you support this particular recommendation coming from the Drummond report, in your ideal world, what kind of timeline would be involved with this?

Mr. Anthony Dale: We don't want to leave you with the impression that things have stood still since KPMG and Drummond—

Ms. Lisa M. Thompson: That's fair.

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Mr. Anthony Dale: There are absolutely improvements being made in the way the ministry and the LHINs manage decision-making in this complex system.

Where I think we need to apply ourselves more directly is in thinking about health system funding reform. This is a good example where we're designing an entirely new way of funding hospitals and other providers. Much of that data and analytical work occurs at the provincial level, because that's where the capacity is for that type of analysis. But the LHINs are also given, as they should be, the authority and autonomy to make other funding decisions, and award allocations and so on. We just have to do a better job of working together—and that includes the provider community—and of lining everything up to maximize our impact.

If you think about funding reform into the future—let's get tangible for a second—hospitals are soon going to be making decisions, working with LHINs, about the future location of health services. They'll want to start thinking about whether or not there's any kind of criteria, specifically around access, that might be needed before we go too far down the road.

A historic example over the past 10 years has been emergency departments in rural communities—and I think part of this can be chalked up to LHINs, at the time, being quite new—examining new and different ways of designing the clinical footprint in a LHIN, saying, "Okay, let's think about the future location of services, including emergency."

What we saw was that there were a few too many isolated regional approaches. That's why it's important, from time to time, that we pull the camera lens back and we say that when it comes to something like emergency departments or other critical services—maybe obstetrics is another example; key tertiary-level services are also good candidates—are there minimum access standards

that we should all be using, from a policy point of view, before making a decision? Is it one hour by land ambulance or by car between the incident being reported and arriving in an emergency department for triage? Is that the right distance? How many members of the population should expect that? Those kinds of standards exist in places like British Columbia.

All we're saying is that there's probably a need to examine the need for some kind of policy parameters or framework for those kinds of decisions regarding access, especially over the next five to 10 years, as funding reform really starts to dig in.

Ms. Lisa M. Thompson: Okay, very good. When you talk about examining that particular model and whatnot—you referenced BC—and growing on your viewpoint of governance, who would you suggest to participate in taking a look and going forward? Do we just leave it in the hands of the ministry and the LHINs, or do we need to pull in more people to this lens?

Mr. Anthony Dale: No, the more people the better. The ministry actually has a very strong track record of this kind of approach. Several years ago, in response to this emergency room question, they appointed the Rural and Northern Health Care Panel. It was actually chaired by Hal Fjeldsted, who is the former CEO of Kirkland and District Hospital. They constituted a committee with a wide range of stakeholders from all sorts of health provider organizations and funders and regulators. It produced a series of recommendations to get to this very question. From our point of view, the next step in the work process is, "Okay, let's now think about where we need to apply it."

Ms. Lisa M. Thompson: Okay. Good. So there are some models out there.

What else do I have? It's interesting as well, coming back to your package: "The OHA recommends that:

"The LHSIA be amended to clarify relationships between the ministry and the LHINs regarding provincial programs and networks."

Leading up to that, you cite existing provincial programs and networks, such as Cancer Care Ontario, cardiac care etc. Is it possible for you to share real-life examples of what isn't happening because we don't have those clear relationships?

Mr. Anthony Dale: Sure. I would just go back to the example I tried to cite earlier. This document here is just the tip of the iceberg in terms of the indicators.

Ms. Lisa M. Thompson: The tip of the iceberg? Yes.

Mr. Anthony Dale: Cancer Care Ontario has an amazing track record of performance and success. It has very strong relationships with hospitals in the wider community. It also has its own performance indicators, and so do LHINs and so does the Cardiac Care Network and so does Health Quality Ontario, so that's how it presents itself.

Again, you've asked that we come here to talk a bit about things through the eyes of the hospitals. They feel as though they're pulled in many different directions, but again, it's all for an amazing good. There's no value in discussing the value of each of these indicators, because they're going to help someone. But we're talking about just making sure that at a system level we're bringing about the long-term focus on the right system indicators so that hospitals and other providers know the long-term trajectory toward change.

Ms. Lisa M. Thompson: Okay, I appreciate that perspective. I'm good, Chair.

The Chair (Mr. Ernie Hardeman): Okay. Ms. Forster?

Ms. Cindy Forster: Thank you, Chair. Thank you for being here today. I'm going to zone in on patient care and what we hear; Ms. Jaczek actually spoke about what she hears in her MPP office.

The government has been moving services from the hospital to the community for a number of years. I was surprised to hear you say that the total number of beds in the province is almost the same as it was in 1998, because certainly, in my own community, we've lost hundreds of beds over the last four or five years. Although we agree that there are situations where this makes sense, we are concerned about the creep of a lot of services that were offered in the hospital to the private sector in the community. Things like physiotherapy, chiropody, breast screening clinics in some situations are moving to the private sector where somebody is actually making a profit off these services, as opposed to using that money for front-line services.

I'll use an example. I was in the hospital—actually asked to go and visit a friend's mother. The family was from Alberta. I went into the hospital to see her. She'd fractured her hip and she had been transferred to a long-term-care area two days after surgery and was waiting five days for physio. She had not been out of bed in five days, and when somebody heard my name from behind the curtain next door, they said, "Is that you, Cindy?" I said "Yes." "Well, I need to see you."

This was an older, retired nurse, who also had been waiting five days for physiotherapy in a bed that probably could have been used—and this is just recently—for somebody else, had the hospital had the money to have the appropriate physio services there in place.

So I'd ask you to comment. Have we closed the beds perhaps too quickly, at the same time as the community services piece isn't up to speed?

Mr. Anthony Dale: I think you're right to ask the question. I don't know the answer, but it speaks to our primary objective, which is capacity planning, and that includes hospital care. But the OHA does accept and support the need to transform the hospital from being all services for all people. It's just too expensive over the long term to maintain that model. Hospitals get involved in other areas of service delivery that others might be better suited to deliver, frankly. That is what's paramount in the eyes of the hospital community.

Ms. Cindy Forster: At the same time, we know that community-based mental health services are promised when inpatient beds are cut, but they often don't materialize. What do the hospitals do in this case? What's the

hospitals' responsibility to these patients in our community who are actually ending up in our jails, ending up in the slammer at police stations?

Mr. Anthony Dale: I think hospitals are part of the solution, but it's not quite the right question to ask—what are we going to do about it?—as though it's solely up to the hospital community itself. I think history has proven that's not a sustainable approach to things. Other providers have much more precise expertise and ability to deal with patients with those kinds of needs. I think it's a good example of the kind of thing that we need to work on even more closely with LHINs and government, if there is proof that patients are falling through the cracks and not getting the care they deserve.

But again, I'd just go back to the core message that we want to leave you with, which is that it's long-term capacity planning—not just planning, but building out that capacity—that is essential to the future of health services delivery.

As you work up to the province's balanced budget target—and all parties are committed to achieving a balanced budget into the future—all leaders are going to have to work with providers to develop a solution.

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If you assume health inflation is about 3.5% a year, and let's say you kept the health budget at its current level for several years—let's say the three or four years in the lead-up to the balanced budget target—we've got to work together to find $6 billion in cost avoidance to achieve that balanced budget target. That's why new and innovative approaches to everything in health care are so absolutely necessary. That's why the hospital sector is in the early days of a massive transformation, using health system funding reform and other change initiatives, to change the way they deliver services.

Again, our goal here is to move resources out of other parts of the system into areas where there is evidence that more capacity is needed and, frankly, patients are going to get the level of care that they actually need. If you are in a hospital, if you are frail elderly and you're in the hospital too long after your hospital care, you're more likely to get an infection, you're more likely to get other health conditions, and it's just not the ideal place for you to be. As a former nurse, I know you know that. That's the theme that's most important to us.

Ms. Cindy Forster: I understand all that, but I think in the meantime, patients are falling through the cracks. I have four or five examples of patients who—it's like they come to the emergency department and they're being pushed back out the door, either to be readmitted later to find out, "Oh, yes, she did have a stroke," or, "Yes, she did have a stroke, but go home and wait by yourself till the stroke clinic opens tomorrow." Or you come in with chest pain: "Yes, you've had a myocardial infarction, but by the way, you had one before. Were you here for chest pain before?" "Well, yes I was, but I was sent home." I hear these stories every single day from people, and my concern is that while it's a great thing to be able to give care to people in the community, there needs to be a transition plan.

Mr. Anthony Dale: Right. Absolutely.

Ms. Cindy Forster: I don't think that that plan is necessarily working. So while we may be reducing health budgets, we're increasing policing budgets, because the police are staying in the emergency departments for three and four hours at a time with mental health patients. The paramedics aren't out being able to do their work because they're remaining, sometimes for a full shift, in the emergency department. So what are your recommendations, from the hospital sector, as to what do we do in the meantime while this shift continues to occur?

Mr. Anthony Dale: We have to get on with the task of knowing precisely how much capacity we're going to need into the future. We know that there are, from the government's action plan, 271,000 people who visit emergency departments when primary care is their more appropriate place for care. We know that there are 140,000 people who are readmitted to hospital each year; after they've left hospital, they come back because they can't access the level of care that they need in the community. That's right out of the ministry's action plan. Those are people who we need to do more to serve and to give them the kind of quality of care that they have paid for all their lives in their tax dollars.

Ms. Cindy Forster: Okay. I want to follow up on the PSLRTA recommendation as well. The OHA is recommending that LHSIA be amended to limit the application of the Public Sector Labour Relations Transition Act only to full-scale transfers, amalgamations and mergers, and that parallel amendments to the PSLRTA would also be required. So when you talk about full-scale, are you talking about a unit? Are you talking about a hospital site? Are you talking about a hospital? Or are you talking about a health system? Because the current arrangement is that if a program moves, PSLRTA kicks in, right?

Ms. Elizabeth Carlton: I appreciate the question. This is a really important area to understand in terms of really being able to fully take advantage of the integration opportunities that are currently within the sector and also within the legislation itself. We had raised this issue because our members are, in good faith, trying to move forward with a number of integrations, and this is something that has been universally raised in terms of our consultation with members as being a bit of a barrier.

Precisely to your question, when you look at—"partially" means anything less than the entire amalgamation. So it could be a unit. It could be a department. It could be any kind of service that supports a department. It has been interpreted very broadly, if that helps.

Ms. Cindy Forster: So you're suggesting that—

Ms. Elizabeth Carlton: I suggested it be to full scale. One of the things that I think hospitals would like to do is moving services that more appropriately should sit in the community or by another agency. I think Andrée could speak to some real-life examples of those. But you would want to ensure that it's a small unit, so even if you're just taking one group of five people, or a back support system out to another agency, that that triggers PSLRTA and the transfer of rights.

Ms. Cindy Forster: For example, you're suggesting if a hospital decided that all dialysis was going to be done in the community, that that program wouldn't fall under PSLRTA because it's only a program. Is that what you're suggesting?

Mr. Anthony Dale: Yes.

Ms. Cindy Forster: Thank you.

The Chair (Mr. Ernie Hardeman): Ms. Gélinas?

M^me^ France Gélinas: Did you want to add something?

Ms. Elizabeth Carlton: No.

M^me^ France Gélinas: I'll start by apologizing. I had to do an hour lead. I just finished, so I missed everything—all the good stuff that you have said. If you've already covered it, just say, "Read it later," and I won't waste your time.

Mr. Anthony Dale: Sure.

M^me^ France Gélinas: The first one I want to ask about: I live in northern Ontario. There are lots of smaller hospitals. Except for the five big ones, they're all small. I just wanted to know: What role does the hospital versus the LHINs play in things like moving physiotherapy from a hospital to the community? So if a hospital decides to no longer offer outpatient physio, does the LHIN get involved, or is it solely a hospital decision?

Ms. Andrée Robichaud: I'm from Thunder Bay, so another—

M^me^ France Gélinas: One of the big ones.

Ms. Andrée Robichaud: Where I come from, it's collaborative. If we're thinking of moving—for instance, we had an asthma clinic that was truly primary care and didn't belong in the hospital and had been—

The Chair (Mr. Ernie Hardeman): If you could just move the microphone over a little.

Ms. Andrée Robichaud: Oh, sorry. It had been delivered in the hospital for quite a while. So when we said that this would be better served in the community, we talked to our LHIN and worked collaboratively in how we found a partner who's interested in delivering that service. We're in the process of doing that right now. We have two or three community partners that are interested, and the LHIN is working with us to find the better fit in moving that forward.

M^me^ France Gélinas: Okay. If we speak specifically for physiotherapy, did you keep your outpatient physiotherapy in Thunder Bay?

Ms. Andrée Robichaud: Our outpatient physiotherapy was not delivered by us; it was delivered by St. Joe's, which is the rehab hospital. So I can't speak to that.

M^me^ France Gélinas: Okay. Just association-wise, is it something that your members do always through the LHINs?

Mr. Anthony Dale: There was, I'd say, within the last four to five years—you're talking about physiotherapy?

M^me^ France Gélinas: Outpatient physio.

Mr. Anthony Dale: Outpatient physio was an area where a lot of hospitals looked to see, "Is this something that we should continue to deliver, or are there other alternate places that might be able to do it?" It was learning from the examination of the accountability agreement cycle that year.

The LHINs and the hospitals did agree to the point that Cindy was making, that we need to get better at transition planning for that kind of transfer of services. In the case of physio, that stood out.

M^me^ France Gélinas: On transition, but the end result, who looks at the fact that the service used to be delivered under layers of oversight in a very secure environment where there was no overcharge and where you were covered—to an environment that has no oversight, the risk of extra billing is there, and most of them were for-profit? In my neck of the woods, we had no OHIP coverage, so it was all private.

Mr. Anthony Dale: That would be the role for the funder and the regulator, ultimately.

Ms. Elizabeth Carlton: But if I could just add, there are provisions in the act currently. If health providers want to integrate services and that means stopping a service, moving a service, whatever, they have to give notice to the LHIN, and the LHIN has to review it. So I don't think health service providers in this environment are unilaterally doing things without a conversation, without advance notice to the LHIN, and, ultimately, usually consulting with the public as well.

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M^me^ France Gélinas: So help me understand, then—a lot of community support services have come here to say, "LHINs gave us a voice, they are respectful of us, they consider us a partner." For a hospital, what has been this change from—you used to deal either directly with the ministry or through their regional office; you now deal through the LHINs. What is the reality for you?

Mr. Anthony Dale: The reality—and we touched on this at the beginning—is much stronger certainty over the accountability obligations for the hospital, especially for the in-patient activity. If you remember, say, 10 years ago, it was very difficult for the ministry and providers to have a common understanding of, literally, what the service-delivery obligations were in return for monies received.

What we've seen through the LHINs and the creation of accountability agreements is a very clear, very specific, very tangible understanding of the performance outcomes. So that's been, in the main, the primary experience of hospitals.

M^me^ France Gélinas: Why couldn't the regional office or the ministry have given you those? Why does it have to go through a LHIN? Why can't the ministry give you a strong accountability performance appraisal?

Mr. Anthony Dale: The ministry had one year's experience with hospital service accountability agreements, and what they found in their experience was that they were drowning in data and information about individual hospitals, and having a hard time understanding how the data and information about performance fit together on a local and regional level. So that's been, I think, the primary benefit.

M^me^ France Gélinas: Okay. And the benefit for you?

Mr. Anthony Dale: Certainty.

M^me^ France Gélinas: Certainty.

Mr. Anthony Dale: Hospitals have much more certainty in their planning horizon than they did before. That's even today, in a situation where the allocations are only being given one year at time and the long-term horizon isn't there the way it needs to be. There is at least much more planning certainty than there was historically in the past.

M^me^ France Gélinas: Okay. Do you see the need for LHINs to do this? You don't see a regional office of a government or a ministry being able to give you that certainty?

Mr. Anthony Dale: Some kind of regional authority, regional function, with the legislative authority to back up words with action is, I think, a very desirable model to have. I wouldn't want to go back to a centralized ministry approach. I don't think you'd find many people who would.

Ms. Elizabeth Carlton: The accountability builds, also, on the planning. The LHINs' role is to fund, integrate and plan, so the planning is done locally, which intuitively makes sense, and then the accountability flows from that: Who is going to do what? One of the features of the accountability agreements that hospitals sign with LHINs is that they can be far more customized than, say, the ones that used to be executed with the ministry.

M^me^ France Gélinas: Is this also true in northern Ontario, where the regional office in northern Ontario used to be pretty approachable?

Ms. Andrée Robichaud: I have not worked under a regional office. I've only been there three and a half years so I've only worked under the LHIN. I was in another jurisdiction prior to that so I can't compare.

M^me^ France Gélinas: In Ontario or outside of—

Ms. Andrée Robichaud: No, I was in New Brunswick.

M^me^ France Gélinas: In New Brunswick? Okay.

So let's take something that's coming: We all know that hospitals do about 600,000 colonoscopies a year; 200,000 of them are going to be moving to the community. None of this came from local planning. The LHINs never came and said, "I think we should move," so how do you balance that?

Mr. Anthony Dale: How do you—I'm sorry?

M^me^ France Gélinas: How do you balance that? You're saying that the strength of the LHIN is because they integrate planning, funding, and have the accountability agreement with you that brings you the certainty that you like, but then we still have governments that come down and say, "You shall divest yourself of 200,000"—

Mr. Anthony Dale: That's one of our main themes in our presentation, which is dealing with what we call "authority grey zones," using language out of the KPMG report and the Drummond report. There are areas where the province, through the ministry and the LHINs, has an interest mutually, but it's not yet clear how they intersect. There are many examples where there is probably a need for an overarching policy framework or parameters for decision-making to guide individual LHIN decisions. So we would agree with you.

M^me^ France Gélinas: So you see this as a clarification. Would you see that the LHINs will have the final say as to, "Do we do this within our geographical area or don't we"? Is this what you're telling me?

Mr. Anthony Dale: I think it's an excellent question. I don't know the answer to it—if they do today or not.

M^me^ France Gélinas: Okay. No, I'm telling you: Would you want them to, given that, to me, you have all to lose—

Mr. Anthony Dale: All to lose?

M^me^ France Gélinas: Yes. What have you got to gain in moving colonoscopies outside your hospital and into the community?

Mr. Anthony Dale: Do you think the system has any potential benefit from that, if it's going to, say, a not-for-profit or—there's all the independent quality oversight from the CPSO and other regulators.

M^me^ France Gélinas: Are there things to gain in the community? Yes, absolutely. But I'm asking you—you're there representing hospitals. You've identified this as a grey area, so I'm asking you: From the hospital association's point of view, how would you like this grey area clarified?

Mr. Anthony Dale: The government has put out a policy framework document, which is a start, which addresses some of the risks that we had originally identified when the proposal was first put out there.

One of the things the government has done to address that risk is give the hospital the approval over a particular divestment in any given community. So it's embedded within the decision-making framework over any contemplated divestment. Cataracts, I know, are open for discussion today, and it's our understanding that if there's a proposal to move a basket of those services out of the hospital, the hospital has to agree to do it. That's a safeguard that we recommended to the ministry, and they accepted.

M^me^ France Gélinas: Okay, but you haven't clarified the grey area. Where would you like one authority to end and the other one to start?

Mr. Anthony Dale: That's why I don't know the specific answer to the question you're asking today. We'd be happy to work on it and get back to you, but I think we're saying in some ways the same thing. There are multiple examples of areas where we have more work to do to understand and sharpen roles and responsibilities. It's just that we're not expert enough in the specialty clinics divestment proposal to answer the question precisely for you today.

M^me^ France Gélinas: Do you see, then, a role for hospitals to have full authority on certain things that affect their hospital?

Mr. Anthony Dale: Full authority?

M^me^ France Gélinas: Could we end up in a situation like that?

Mr. Anthony Dale: Could you be more precise with your question?

M^me^ France Gélinas: Yes. Once you have a grey area, it's an area where we don't know if it should be ministry, if it should be LHINs or if it should be a coordination where one ends and the other one starts. I'm asking you: Could you see a role where it would become all ministry?

Ms. Elizabeth Carlton: There are some roles now that are purely ministry: policy-setting standards and setting all the rest of it, and there are some roles that are uniquely LHINs. I think what we're hearing from our members is there is a bit of a grey zone, and that's what's been identified by Drummond and others.

It's a bit unclear who's on first: What is the appropriate level of government to go to? I think that's just what we're getting at. When the legislation was introduced we had no experience to go on and so it tried to kind of set boundaries. What we're hearing and you're hearing from us is that maybe it's time to revisit that and say, with sharper focus, "Here are some areas that really should be ministry clearly and here are some areas that are clearly LHIN authority."

M^me^ France Gélinas: And none of that work has been done?

Mr. Anthony Dale: Some, in different policy areas. We cited the future of health system funding reform as a great example of an area where we need to do a lot more work in understanding the policy framework for future decisions, especially regarding access.

M^me^ France Gélinas: Okay. Any other, or—

Mr. Anthony Dale: That should do.

M^me^ France Gélinas: Okay. What is the way to bring those discussions forward? What is the preferred way to clarify the grey area?

Mr. Anthony Dale: In our material, we talk about taking a methodical and deliberate approach to understanding where the opportunities and the risks are in that decision-making space. From our point of view, health system funding reform is an area where we do need to work with the ministry and the LHINs on the policy parameters for decision-making, and the ministry is very open to that. We work with them very closely every day. We've been concentrating in the last three years on strengthening the technical underpinnings of the formula behind funding reform. We have more work to do, but now we're turning our eyes to the policy considerations.

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Ms. Elizabeth Carlton: This way, maybe, through what you've heard in these hearings, you may have some ideas to put forward as well. But certainly, as we said, the ministry and the LHINs initially tried to come up with sort of a compact of who's going to do what, and maybe it's time that they revisit it and reach out to stakeholders and see where the areas are where there needs to be a clear delineation. One example we hear is that there's policies that come down, but one LHIN might sort of apply them differently. There's always an opportunity for interpretation of a policy. It's that sort of thing that our members raise as questions, beyond the obvious gaps, perhaps, in roles. But I think there is scope and it's an opportune time to perhaps have a close look at it.

M^me^ France Gélinas: I would say, if you've done any work or invested any brainpower into this area, send it our way.

Ms. Elizabeth Carlton: Yes.

Mr. Anthony Dale: Sure.

M^me^ France Gélinas: This is certainly a huge part of what we're doing here as to: Will the LHINs stay the same, will their power be extended or shrunk, and how will the grey area be clarified? A lot of people that have come from the community support sector have been very consistent in what they want. We've heard very little from hospitals, to the point where it was worrisome.

So my next question is: We did travel to nine different communities. Every single one of those communities, except one, Vankleek something—

Ms. Helena Jaczek: Vankleek Hill.

M^me^ France Gélinas: Vankleek Hill—had a hospital. None of the hospitals participated. Any tidbits as to why that is?

Mr. Anthony Dale: Well, I think this review was supposed to happen in 2010-11. Then there was a legislative change to move it to some out-years, and then that date came and went. I guess about two years passed between that deadline and your first meetings in December. So the sector had assumed, frankly, that this review would never happen. Your hearings have happened very, very quickly, and I know why that's the case—you've got business to conduct—but when hospitals have to prepare for a submission before a legislative hearing, it's time-consuming. They're very conscientious. They want to make sure that they're representing themselves appropriately. The hearings were very quick, so that's probably why you experienced what you did.

Ms. Elizabeth Carlton: And also knowing that we would be making a submission, as we typically do. All of the LHINs were represented in our working group, so everyone had an opportunity to feed into this process.

M^me^ France Gélinas: I can tell you, it was surprising and disappointing that the hospital sector did not participate. It is a huge sector money-wise, people-wise, resource-wise, in every way you want to look at it, and you are it. You are the voice that will talk to us about how regionalization has affected your sector.

Go ahead.

Ms. Cindy Forster: Niagara. Niagara participated.

M^me^ France Gélinas: Oh, yes. True.

Ms. Helena Jaczek: And North Bay Regional Health Centre.

M^me^ France Gélinas: They came to Sudbury?

Interjection: Yes.

M^me^ France Gélinas: I was there.

Mr. Anthony Dale: I'm sorry you feel that way, but all I can do is say that the review was really supposed to take place four years ago. Then there was a legislative change, and then that came and went. Two years passed. If you were us, what would you assume?

M^me^ France Gélinas: Okay. I don't know if you've been following the review at all—

Mr. Anthony Dale: Yes.

M^me^ France Gélinas: —and heard some of what the presenters had to say. Are there scenarios that really would not be acceptable to OHA?

Mr. Anthony Dale: Meaning what?

M^me^ France Gélinas: Meaning some of the ideas that have been put forward by—

Mr. Anthony Dale: You mean structural change?

M^me^ France Gélinas: Yes.

Mr. Anthony Dale: I think on structural change, we'd say this: You'd probably never design the health care system to look the way it does today if you could start from a blank sheet of paper from scratch. But there's two ways to look at things: the theoretical and then the practical. What we are very concerned about is disruption in health system planning and decision-making at a pivotal juncture in the province's health care system transformation and the lead-up to the balanced-budget target.

Our major message, before you got here, was all about health system capacity planning and capacity building. You will know from our discussions one-on-one that our overarching concern is building capacity in the community and long-term care in particular in the lead-up to that balanced-budget target, because as you get close to 2017-18 and the compression on hospitals and even the rest of the system, you know how highly interdependent it is. We know from experience that in 2006, when the long-term-care construction ended, within a 60- to 90-day window, hospitals at the tertiary level in particular started saying to us, "Why are we being inundated with ALC patients? We don't understand what's going on." It was a simple connection to long-term care.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes all the time. I'm sure that the best part was yet to come, but we must move on.

To the government: Mr. Colle.

Mr. Mike Colle: The best is yet to come.

It's interesting. I think it's sort of a typical comment I get. I talked to a gentleman who had a quadruple bypass at the local hospital. He was in my office, and I said, "Didn't you get great service and doctors and so forth?" He said, "Yes, fantastic doctors, a fantastic hospital." And I said, "And that's covered by the public health care system." He said, "Yes, fantastic. But that darn parking fee I had to pay—$40. I had to pay $40. You've got to do something about the $40." I said, "Okay. I get it."

But just getting back to our purpose here: It's to try to look at the legislation as it pertains to LHINs and see how we can improve it and make recommendations to improve it so that the Ontario Hospital Association and all your partners will be able to basically provide better, more efficient and more effective health care and just to get rid of some of the obstacles or encumbrances.

I guess it comes down to: What would be one area, one thing—I know it's too simple to say "one thing"—where we might be able, as a committee, to make some recommendations to make all the 440 hospitals across Ontario—

Mr. Anthony Dale: A hundred and forty-nine.

Mr. Mike Colle: How many?

Mr. Anthony Dale: One hundred and forty-nine, with 225 sites.

Mr. Mike Colle: I don't know where I got the number 440. But anyway, so how—

Interjection.

Mr. Mike Colle: Yes, municipalities. Excuse me.

What should we recommend and look at recommending that might seem fruitful for improved delivery of services in our hospitals especially?

Mr. Anthony Dale: I think I would go back to the core theme of our presentation, which is that the ministry and LHINs, along with their providers, create a very deliberate, evidence- and population-based approach to planning for future health system capacity building and that we get on with building it. How many community services, how many extra thousands of hours do we need in York community and in others? How many new long-term-care beds do we need, not just next year but five years and 10 years from now? Because again, as you move toward that balanced-budget target, which all three political parties acknowledge is absolutely necessary—we're talking about quite significant compression on the system—let's make sure that we're building the pressure valves that can take the patients out of hospital as they're being discharged in a very timely manner, get them to the right place where they get the right level and quality of care that they deserve, and we don't readmit them to hospital and go through the whole cycle over again, where the patient isn't getting the kind of care that they frankly deserve. That's what capacity planning and capacity building is all about.

Mr. Mike Colle: So therefore we should enrich, enhance, the LHINs' capacity planning enhancement function—

Mr. Anthony Dale: We need to arm the LHINs with evidence and data and information that is going to guide strategic decision-making into the future about what they need.

Mr. Mike Colle: Better arm the LHINs?

Mr. Anthony Dale: Better arm the LHINs, with the help of the ministry, with evidence, data and hard information about precisely what's needed in northwest Ontario: How many extra thousands of home care hours? How many extra long-term-care beds? How many new assisted living spaces are needed, and primary care access in terms of hours of coverage? You can predict this with a reasonable degree of precision, and that's what we're saying we need to do. Right now, what we do is, we have decisions made on a kind of annual basis, or an incremental basis, maybe two years out. We need to get out of that habit and we need to start thinking about the long term.

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Mr. Mike Colle: So the LHINs should be somehow—again, what we're looking at is structural change here,

because legislative change is structural change. So something that we could recommend that the LHINs—an added function within the LHINs or an added emphasis within the LHINs that would enable them to basically do almost an ongoing analysis of the data that not only analyzes present data but future projections, and that would be a more comprehensive, more robust part of the LHIN function. As a layperson, I'm trying to express it as best I can.

Ms. Andrée Robichaud: I think it's hit and miss right now for northwestern Ontario. We had a huge issue around ALCs, and your government announced $14 million to help our community, but our LHIN had done the work. Our LHIN had projections on ALCs. My hospital was—I have 375 beds, and at one point in time I had 81 ALC patients within my beds. So it was really affecting—we had to cancel surgery.

But given the data and the information, we, with the LHIN, could speak to the government and say, "Look, here's the reality of the situation." I think what we're saying is that we have to do that consistently. If you're going to really look at the capacity of your health care system, it has to be done consistently throughout the 14 LHINs with a view of, "Here's where we're going. This is what we're going to need in the future." Because otherwise, you're always reacting like we did in northwestern Ontario.

Mr. Anthony Dale: There's probably a straight line in your constituency offices between complaints and concerns that you hear—rightfully so—from patients and clients about, "I can't get enough home-care hours for my mom; I can't get my grandparents into a long-term-care facility." There's probably a direct line between that gap and the need for the system to forecast and make deliberate decisions about how many more long-term-care beds you're going to need in your community to prevent that from ever happening again to another patient. We're trying to connect it to the person, but that's what we're saying.

Mr. Mike Colle: But in part, what I hear from Andrée is that the LHIN may have that capacity—

Ms. Andrée Robichaud: But it's not consistent. Some plan on certain things, and others plan—as a healthcare system, as a government, you need to know what exactly is coming in the next 10 years: What do I need to be able to fund and what are my needs? So you really need to have the system view versus—

Mr. Mike Colle: The system what?

Ms. Andrée Robichaud: The system view of what's coming in the next 10 years and what are my needs, in order to be able to allocate the funds that you have in an efficient manner.

Mr. Mike Colle: Unless you put in a framework or a legislative parameter—because it appears it isn't there in a robust, comprehensive fashion. Therefore, you're saying we have to somehow find a way in our recommendations, in terms of this legislation—that we find a mechanism that enables this type of analysis to happen regularly, routinely, and that there's almost a direct connection with this routine analysis and the Ministry of Health.

Mr. Anthony Dale: Yes. And you wouldn't necessarily need a legislative change to do that, but yes.

Mr. Mike Colle: That's where we can do something, though. That's why I'm trying to find out how we could maybe help achieve that through our recommendations. But we could put that forward in a recommendation—

Mr. Anthony Dale: The terms of reference for this review are very broad. They're not restricted just to the language of the Local Health System Integration Act. So I think, personally, you've got the latitude to comment on that.

Mr. Mike Colle: We have latitude to comment, but I think it might be more effective to have some very, very focused proposals that might get attention. That's why I look for your guidance on that, because you're in the front lines on this.

The other thing that comes to mind is, I think, Mr. Dale, you mentioned the hospital restructuring commission that we went through back in the 1990s. I lost two hospitals basically overnight; they have not been replaced. They are finally building—12 years later, we're getting the Humber River Regional built. It took 12 years to fill a gap.

What I'm trying to bring to mind is that you've got the LHINs; you've got the Ministry of Health. There seems still to be some kind of disconnect, and it's not, I think, the fault of the hospitals. We were just at an event last night about cancer care at Scarborough Centenary and the Rouge Valley Health System and an amazing staff there that deals with cancer patients, oncology, on a regular basis. But it just reminds us of the fact that sometimes there is a lack of buy-in by the public because the system is very complex, and you're usually interfacing with the system at a time of trauma. We have the LHINs, and most people don't even understand what they do unless you're inside the business. Then you've got the Ontario Hospital Association. You've got the hospitals that are working 24/7 keeping people alive, and you've got the hospital boards etc.

Is there anything that we might be able to look at creating that would almost bridge that gap, that would give ordinary people an opportunity to understand this very, very complex system that is very technical, very scientific, sometimes very distant? I think that's one way that you might sort of—you're never going to get rid of everybody's anxiety, but I'm saying in terms of just making people understand that this work is going on, that you are being taken care of by this future planning, and it's for your good. Other people, when they see change or they say, "Well, I want something today, but tomorrow I'm not worried about," and meanwhile you're looking at future projections. Right?

But there isn't anybody out there to try and explain how this is to their benefit. Everybody says, "I want my health care. I want my doctor. I want that operation. I want that home care." They want it. Is there a possibility of some kind of blended focus point where people could

somehow connect, not on a daily basis, but just something that's out there that connects the LHINs to the hospital association, to the Ministry of Health? Because everybody is obviously working to the limit. Whether it's PSWs, doctors or nurses, community health centres, I can't remember a time when it wasn't busy in these places. There was never such a thing. So is there any mechanism that we might be able to explore?

Mr. Anthony Dale: I think that's the very purpose behind the government's health links proposal, which is now growing to some 70-plus individual projects. Just to describe them for a second, what we're doing is we're thinking about the people in any local community who have the most intense needs, typically frail elderly, chronic conditions, perhaps there are some mental health concerns as well, and through the health links initiative that the ministry is sponsoring, we're trying to treat every single one of those patients—we know them by name; we know who they are—and design the services around each and every individual need. That's what a health link is, in principle, supposed to do.

You're then getting the providers trying to concentrate on—instead of 10,000 people across their whole community, they're focusing in on, say, 80 or 100, the people who they know are bound to come back to their emergency room because they can't get the primary care that they should or the community services. We're trying to design an entirely new way of caring for those people as individuals at that local level. When I listened to what you were saying, I think that's the germination of the government's very own health links proposal.

In response to something else that you said, for us it means building on the action plan, which I think is a comprehensive and clear and well-articulated short- to medium-term plan for the transformation of the system. But what we want to do is build on top of that and go even further out and pick some very clear and specific objectives that the provider community—

The Chair (Mr. Ernie Hardeman): We'll have to go further out on the next round.

Mr. Mike Colle: Okay.

Mr. Anthony Dale: Sure.

The Chair (Mr. Ernie Hardeman): To the official opposition.

1540

Mrs. Jane McKenna: Thank you so much. Do you go by Anthony?

Mr. Anthony Dale: Yes.

Mrs. Jane McKenna: Sorry; I wasn't here at the beginning. Hi, Anthony. Hi, everybody.

I haven't had time to read totally through this and I do apologize, as well, because I like to sit from beginning to end so that I have proper questions to ask. But I am grateful for you being here because, in the end, we ultimately have been sitting through all this. I know that you made a comment to Ms. Gélinas that all of a sudden, after—it was supposed to be reviewed, I think, at five years, and all of a sudden you just got this, and so it was hard to get all that information together. We're very grateful. It is time-consuming to put a proper presentation together.

I guess I want to run through a few things. One consistent thing that we've heard said over and over again is that the LHINs, maybe by no fault of their own—or fault of their own—are very much stuck in their own silos. Communicating, from one to the next LHIN when you had a great idea—clearly, one size doesn't fit all and they've got different issues in each place. Would you say that's a pretty fair statement, that they're not communicating one to the next?

Mr. Anthony Dale: I wouldn't say that's entirely fair, no. I think over the years, in our experience with LHINs—you have to keep in mind that they were created from scratch and they've grown and developed over the years. We've seen lots of evidence of them communicating well with each other or engaging well together with, say, the hospital community. Before you got here, I cited that a major partnership that we have with them relates to designing the planning and accountability framework for hospitals and the annual cycle of accountability.

Where I think we run into some grey zones is when we start dealing with what are, in effect, very powerful strategic decisions at a local level that may not be being made based on the same considerations and policy framework in another part of the province. That always makes people ask questions.

What we do think needs to be done is to make sure that we're looking very carefully at any kind of very important grey zones where we need to think ahead and decide if some policy is needed. The future of health system funding reform is a very good example. In the next 10 years, you will see a total transformation in the way that hospital services are delivered in this province, all designed around improving quality and making the system even more efficient. That means, probably, changes in the places and the ways in which services are delivered to people.

Let's think ahead and say, "Okay, are there policy considerations? Are there things that we should think about before anybody goes into making a decision?" Maybe it relates to access and how far somebody has to travel or drive to get this kind of care before we say, "Aha! Yes, let's go ahead."

We've seen historical examples of that using emergency departments and obstetrics—those are typically the ones that people are most familiar with—but in the future I think we need to make sure we're looking at the host of hospital-based services and understanding those policy considerations.

Mrs. Jane McKenna: Thank you. We had Dr. Wooder here last week, and he was saying that there were some LHINs that were very successful; clearly, some that were not. Why do you think that is? If you're all running—I guess I'll jump in here, because that's kind of an open-ended question.

Mr. Anthony Dale: Why don't you go ahead and answer it?

Mrs. Jane McKenna: I'm not going to answer it. The number one theme that we've heard over and over

again—and anybody else can say if they've maybe heard it differently than myself on this committee—is the understanding of everybody's job description. You brought this up; I haven't gone through this completely, but clearly that seems to be an issue here. Would that not have a huge barrier on how successful you are if you don't really understand your job description and what that is?

Mr. Anthony Dale: It's certainly a hindrance, but I guess I would just put a little asterisk beside what you're saying in that this is a really, really complicated area and it's not always going to be easy to draw a neat and tidy box around everybody's role and responsibility either. There is a lot of integrated responsibility between the LHINs and the ministry, just out of the subject matter they deal with.

What are the areas where there's a strategic provincial interest? That actually exists in the legislation today. It's quite clear that where there are areas of clear strategic provincial interest, the ministry and government retains the right to involve itself. I think that understanding those areas and future access to services because of, say, funding reform, is a very good example of the kind of thing that we need to work on further together—the providers, LHINs and the ministry.

Mrs. Jane McKenna: Yes. I guess the most important thing is that the success of how you're doing is measured by the success of the patient, right?

Mr. Anthony Dale: Yes.

Mrs. Jane McKenna: That's the bottom line, following that person from beginning to end. And I see here, on the second page, that you have done numerous—I think you have a committee here with all the CEOs for the 14 LHINs, the hospitals. When you got all that information together, clearly that's what came out with your recommendations in the end, but that's an ongoing process, right? The thing that I think I struggle with most is that the LHINs have been functioning for eight years, and yet we still have to keep going further, because clearly there are major issues, right?

I recognize the fact, so by no means am I saying I don't understand it is very complex, but so are MPPs' roles, and we couldn't say to you today, "Well, that's really not my job description. I really don't know what it is." You just jump in with two feet and you've got to do it and that's the end of it, right? There's no saying, "Well, it's complex. I really don't understand. There's jobs, bureaucrats, silos." We've heard those kinds of statements numerous times over and over again. Do you think there's fairness in saying that, and that there's duplication and people are just very confused on what their actual roles are?

Ms. Andrée Robichaud: MPPs have existed for many, many years, and when you make governance changes in a health care system—I used to be a deputy minister in another jurisdiction. When you develop a piece of legislation, you have all kinds of intents for it, but it really does surprise you as it evolves, because it doesn't really happen like you thought it would.

Mrs. Jane McKenna: Yes.

Ms. Andrée Robichaud: You guys know that more than I do. The LHIN is in evolution, and I think that you as a group have an opportunity to say, "Okay, here's where we need to tweak it to make it more where we wanted it to go initially. Maybe it's better that that now is done at the provincial level and this is done at the local level." You have a wonderful opportunity here to help in clarifying those roles and moving us to another level, because it had to be evaluated. I think people recognize that when you put in a new piece of legislation, you need to evaluate it, because it's not going to grow up to be what you thought it was going to be.

We're now at the stage here saying, "Here's what we think are some of the tweaks in the document that we're putting forward," and I'm sure you've heard a lot of other pieces where people have a different view of things. I think if you put that altogether, you'll probably help us move it in the right direction.

Mr. Anthony Dale: Absolutely.

Ms. Elizabeth Carlton: I can just briefly add that one of the things that was—you know, hindsight is 20/20, but when you look at when the legislation was brought in, none of the things we take for granted now, in terms of the health system transformation, were in play, right? So even when we look at this, some of the murky areas for our members is the funding: "Who's on first? Who do we go to?" But the whole funding reform hadn't happened at that time. There was no Health Quality Ontario at the time; no Excellent Care for All Act. None of these things were in play. In terms of primary care, some of the changes there hadn't taken place.

So it is, in a sense, a very opportune time to take stock and say: Given where the system is now, does this roster of competencies and functions still make sense? Do we need to give it greater clarity, given where we are? I could certainly see there being some ambiguity about, "Oh, is this my role? Is it the ministry's? Is it public health's? Who is it?" So it is time to kind of take stock.

Mrs. Jane McKenna: Really, when you say, "Whose role is it?" I just find it odd that someone would even be asking that question. I mean, MPPs have been around for a long time, but I've only been in it for two and a half years. So it's, "Here you go, here's your office, see you later, figure it out," kind of thing.

I find it odd when we have people come in and sit here and say, though, that the clarity—clearly it is, because if you've read any of the Hansards we've had in here, it is the clarity and the definition of what each role is doing, the duplication, the silos. It's been repetitive over and over again. I personally find it odd that you would need clarity on who's doing what. Clearly you do, but—

Ms. Elizabeth Carlton: Well, if we just work through the funding examples, maybe, in the past it was global funding in the ministry, and then it might have just flowed to the LHIN and they would allocate, but now—maybe Anthony or Andrée want to speak to how that's changed dramatically—the ministry has a significant role in terms of allocation of funding. So it's not crystal clear the way it might have been intended here.

1550

Ms. Andrée Robichaud: The way I would see the confusion is: When do you need a provincial standard and when do you need local input? Sometimes that's contradictory in certain areas; all right? I think that Member Gélinas talked about devolving certain things to the community. In certain areas, devolving certain procedures to the community will be an opportunity for them to do other work, because they're racked up in the queue; there is more work to be done. In other areas, that's probably their livelihood. Therefore, you need that local input, but you also need those provincial standards. I think that's where the confusion starts. If you don't really have a good collaborative relationship, that gets tense. I think that's what you heard.

I've been here three and a half years, and every time I see that happen it's because you have the ministry that's trying to do their role and set that provincial standard, because every Ontarian should have the same standard of care everywhere they live, but when you look at the local reality, it becomes very complex. I think that's where it becomes very tense.

Now that you have almost a decade of experience, we can go back and say, "Here are some of the areas"—and you can say to the ministry and the LHIN, "Go back and look at where your problem areas were," and in retrospect, look at that and say, "How do we handle that better, and how can we put the mechanisms to ensure that?"

Mrs. Jane McKenna: That's great. Thank you so much. It is going to be a process. That's what we're here for, is to make things better and find the recommendations to obviously do that. I can speak as one MPP—I won't speak for anybody else here, but it is—

Mr. Mike Colle: You can speak for me too.

Mrs. Jane McKenna: Okay, thanks, Mike. I'm going to speak for Mr. Colle.

It is very much a fragmented system; right? When you're in it as an MPP, and the people who are coming—you think, "My gosh, I'm struggling trying to get through this; how the heck is the actual layperson who is out there trying to do this because I'm struggling?"

As much as we have all those tools in our hands, it can't be this difficult if we're trying to be patient-centred. If the success of measuring where we're going is measured by the success of the patient, then we clearly have to make recommendations to make things better and clarify what is the best route for all of this.

Mr. Anthony Dale: You're right. I guess what we would add is that sometimes structure isn't the solution you think it is. If structure was the solution that you think it is, then by all reports, Alberta would have the country's highest-performing health care system because they've centralized everything. So by centralizing everything you would easily assume, "Of course things are going to get better," because you've got one scope of authority and one set of decision-making levers and it will all fall into place. I think the reality they experience in Alberta is dramatically different.

What is most important to us is the patient experience. The individual patient and client is on a journey through the system at probably the most difficult time in their life, and how does the system better concentrate its time, energies, focus, and care around them as a person? There is so much work going on to try and accomplish that, it's just that structure isn't always the answer that everyone thinks it is.

Mrs. Jane McKenna: I respect that.

My colleague is going to take a turn. Thank you.

Ms. Lisa M. Thompson: Quickly, I was intrigued by the fact that you brought up BC as possibly a model to follow or not to follow. In my riding, I have a hospital CEO who came from that system, and I'm just wondering: Are there best practices that we should be thinking about when you talk of community governance, married with what we have today?

Mr. Anthony Dale: There is no community governance in BC. There's a regional health authority with a board that's appointed by the provincial government. What BC does have is—my reference earlier was about policy around access standards. So when they look at things like emergency departments—just because it's a clear example to use—they literally have a policy that guides decision-making that says that 97.5% or 98% of a population within this geographic area should be able to access an emergency department within one hour—

Ms. Elizabeth Carlton: Thirty minutes.

Mr. Anthony Dale: I believe it is one hour; the 30 minutes and then the 30 minutes golden rule. That's what guides their decisions on service location and service change. That's the kind of best practice that, yes, Ontario, should look for. We made that submission to the rural and northern panel that Hal Fjeldsted chaired, actually, because it touched on issues that were related to the Niagara Peninsula at the time.

Ms. Lisa M. Thompson: Okay. Thank you for clarifying.

Mr. Anthony Dale: Not at all. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time of all three parties. Thank you very much for being here today. We very much appreciate you taking the time and preparing. I apologize for having to cut some of the answers short.

Mr. Anthony Dale: Not at all, Mr. Chair.

The Chair (Mr. Ernie Hardeman): As you can see by the look on my face, I'm very sorry.

Thank you all. That concludes the hearings, the delegations, that we have today.

SUBCOMMITTEE REPORT

The Chair (Mr. Ernie Hardeman): You will notice on the agenda that our next item is committee business. We have a programming motion, as was requested by the committee—I think it was at our previous meeting or two meetings ago—where they wanted a programming motion for those items that were on the committee's agenda

at the time. We have that programming motion from the subcommittee.

Ms. Forster, you have the report from the subcommittee.

Ms. Cindy Forster: Thank you, Chair. Your subcommittee met on Tuesday, March 25, 2014, to consider the method of proceeding on Bill 135, An Act to protect pupils with asthma, and all the other bills referred to the committee as of March 25, 2014, and recommends the following:

On Bill 135, An Act to protect pupils with asthma:

(1) That the committee meet in Toronto on Tuesday, April 8, 2014, for the purpose of holding public hearings.

(2) That the committee Clerk post information regarding the hearings on the Ontario parliamentary channel, the Legislative Assembly website and Canada NewsWire.

(3) That the deadline for requests to appear be 4 p.m. on Friday, April 4, 2014.

(4) That witnesses be scheduled on a first-come, first-served basis.

(5) That witnesses be offered 10 minutes for their presentation followed by 10 minutes of questions divided equally among the three caucuses, for a total of 20 minutes.

(6) That the deadline for written submissions be 4 p.m. on Wednesday, April 9, 2014.

(7) That the committee meet for clause-by-clause consideration on Tuesday, April 15, 2014.

(8) That the deadline to file amendments with the committee Clerk be 4 p.m. on Thursday, April 10, 2014.

On Bill 172, An Act to amend the Ministry of Training, Colleges and Universities Act to establish the Advisory Council on Work-Integrated Learning:

(9) That the committee meet in Toronto on Tuesday, April 29, 2014, for the purpose of holding public hearings.

(10) That the committee Clerk post information regarding the hearings on the Ontario parliamentary channel, the Legislative Assembly website and Canada NewsWire.

(11) That the deadline for requests to appear be 4 p.m. on Friday, April 25, 2014.

(12) That witnesses be scheduled on a first-come, first-served basis.

(13) That witnesses be offered 10 minutes for their presentation followed by 10 minutes of questions divided equally among the three caucuses, for a total of 20 minutes.

(14) That the deadline for written submissions be 4 p.m. on Wednesday, April 30, 2014.

(15) That the committee meet for clause-by-clause consideration on Tuesday, May 6, 2014.

(16) That the deadline to file amendments with the committee Clerk be 4 p.m. on Thursday, May 1, 2014.

On all the other bills:

(17) That the remaining bills referred to the committee be considered in the following order:

(1) Bill 104, An Act to provide protection for minors participating in amateur sports;

(2) Bill 137, An Act to amend the Public Transportation and Highway Improvement Act and the Highway Traffic Act to construct paved shoulders and permit bicycles to ride on them;

(3) Bill 142, An Act to proclaim Major William Halton Day;

(4) Bill 166, An Act to amend the City of Toronto Act, 2006 to allow the city of Toronto to pass a ranked ballot bylaw for city council elections; and

That the subcommittee meet at a future date to further consider the method of proceeding on the above-noted bills.

(18) That the committee Clerk, in consultation with the Chair, be authorized prior to the adoption of the subcommittee report to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

I move that the report of the subcommittee be adopted.

The Chair (Mr. Ernie Hardeman): Thank you very much. You've heard the motion. Discussion on the motion? Ms. Jaczek.

Ms. Helena Jaczek: Yes, Chair, I would like to propose an amendment to this motion, and I do have copies here for the Clerk. This programming motion relates to private members' public business. This is a situation where we're all equals here. It is not, I don't think, and should not be, a partisan issue. As I argued during the subcommittee meeting, I think it is only fair that private members' business, one from each party, be considered in the top three. My amendment will put Bill 166 second in the order, subsequent to Bill 135. So this does follow a chronological order. In other words, as you will see from the wording of the amended motion, we would go with Bill 135, Bill 166, Bill 172—so that's one from each caucus chronologically—and then the remaining four, I believe it is, chronologically after that.

1600

The Chair (Mr. Ernie Hardeman): Thank you very much. An amendment has been moved. The amendment now is up for debate. We can move to debate on the amendment to the original motion. When we get the amendments debated, we then go back to the motion as amended or as not amended—

Ms. Helena Jaczek: And I will be asking for a recorded vote.

The Chair (Mr. Ernie Hardeman): Okay. With that, you all have a copy of the amendment. Further debate on the amendment? Yes, Ms. Forster.

Ms. Cindy Forster: Can I move a subamendment?

The Chair (Mr. Ernie Hardeman): An amendment to the amendment?

Ms. Cindy Forster: An amendment to the amendment.

The Chair (Mr. Ernie Hardeman): Okay.

Ms. Cindy Forster: The amendment would be—I don't have it in writing, but we'll put it together—that Bill 166, An Act to amend the City of Toronto Act,

would follow Bill 172, which was the decision of the subcommittee, that Bill 135 be followed by Bill 172, and then chronological order. But I would move that Bill 166 be third in line.

The Chair (Mr. Ernie Hardeman): So just for clarification, your amendment would be, in number 17, we change number 1 and put number 4 above number 1.

Ms. Cindy Forster: That's correct, and then everything—

The Chair (Mr. Ernie Hardeman): And renumber it back down.

Ms. Cindy Forster: Everything else would move down.

Interjection.

The Chair (Mr. Ernie Hardeman): I'm just informed—to make sure we keep everything in priority, the amendment you're making is an amendment to the amendment, so we have to amend it and put 166 following 172. The amendment has Bill 166 as number 2, and your subamendment is to move it down and move 172 ahead of 166.

Ms. Cindy Forster: Under 17, 166 would be number 1 and then everything else would just move down.

The Chair (Mr. Ernie Hardeman): My challenge is that—

Mr. Mike Colle: Could we have this in writing? Because it's confusing—

The Chair (Mr. Ernie Hardeman): I'm just going to suggest that we can vote on this amendment, because what the present amendment to the amendment does is it amends the original motion. You can do that after we deal with the amendment that's before us now, rather than amending the amendment, because once we vote on the amendment, there's debate on the motion again and you can make that amendment then. Rather than trying to amend the amendment, you really want to go back to the original motion first.

Ms. Cindy Forster: Normally, you would debate the subamendment, and then if the subamendment passes, you would then debate the amended amendment.

Mr. Ernie Hardeman: If that's the case, then we have to get it printed, because then, as Mr. Colle says, it gets too complicated having people vote and debate it without actually seeing what we're debating. Because if you're going to amend the amendment, you have to take 166 out of the amendment and and put 172 back in the amendment to the amendment.

M^me^ France Gélinas: Just to be clear, all we do is we take the bold line that says "Bill 166," and we replace it by the bold line that says "Bill 172". That's all. Our subamendment wants to switch 172 for 166?

Ms. Cindy Forster: No, no.

Ms. Helena Jaczek: No. We want 166—

Ms. Cindy Forster: With dates.

Mr. Mike Colle: We need it in writing. This is confusing.

Ms. Cindy Forster: And that was going to be part of my amendment, if I ever get to it.

The Chair (Mr. Ernie Hardeman): I'm at the committee's mercy here. Do you want to amend the amendment, or do you want to deal with the amendment and then amend the original motion with a second amendment?

Ms. Cindy Forster: Well, Chair, should we take a break for five minutes, and we'll give you the amendment to the amendment?

The Chair (Mr. Ernie Hardeman): A break has been requested; a five-minute break.

The committee recessed from 1606 to 1611.

The Chair (Mr. Ernie Hardeman): Committee, come back to order. We're presently dealing with the amendment to the amendment. Ms. Forster?

Ms. Cindy Forster: I will withdraw the amendment to the amendment at this point.

The Chair (Mr. Ernie Hardeman): Okay then, the amendment to the amendment is withdrawn. We will be open for discussion on the amendment to the report. Yes, Mr. Colle?

Mr. Mike Colle: I'm speaking in favour of the amendment to the report. As you know, Mr. Chairman, when the subcommittee report came back and said that the chronological order would be 135, which deals with protecting pupils with asthma, then Bill 172, to amend the Ministry of Training, Colleges and University Act, and then it says "other bills," I don't think the subcommittee report—does it even mention 166?

Ms. Helena Jaczek: It's at the bottom of the list.

Mr. Mike Colle: Okay, yes. It was my understanding that—yes, it's with the other bills, if I'm not mistaken.

The Chair (Mr. Ernie Hardeman): They're all listed, yes.

Mr. Mike Colle: Because I thought in the discussion we had here that the agreement was that, as a committee, we would look at this in chronological order in terms of the way they were presented in the House. My understanding is, Bill 135 was there, then 166 was introduced and then 172. That's my understanding. Is that correct, Madam Clerk, in terms of the way they were—

The Chair (Mr. Ernie Hardeman): I think at the last meeting, there was much discussion as to what the committee should or shouldn't be doing. But I think the direction to the subcommittee was to bring back a report on how to deal with all the business that was on the agenda for the committee and to put it in an order of how the committee would then propose to deal with it for the committee to discuss. That is what this subcommittee report does, but it only actually itemizes the first two because circumstances could change and they will have to meet again to deal with the actual timing of hearing the other bills.

Mr. Mike Colle: But I just want to get the clarification in terms of the way they were introduced in the House; am I correct?

The Clerk of the Committee (Ms. Valerie Quioc Lim): Bill 166 was referred to the committee on March 6, 2014, and Bill 172 was referred to the committee on March 20, 2014.

Mr. Mike Colle: And Bill 172?

The Clerk of the Committee (Ms. Valerie Quioc Lim): March 20, 2014.

Mr. Bas Balkissoon: And 135?

The Clerk of the Committee (Ms. Valerie Quioc Lim): Bill 135 was referred to the committee on December 5, 2013.

Mr. Mike Colle: Let's get that straight again. So 135 was referred to the committee what date?

The Clerk of the Committee (Ms. Valerie Quioc Lim): Bill 135 was December 5, 2013.

Mr. Mike Colle: Okay, so that was first. Second, 172: When was that referred to the committee?

The Clerk of the Committee (Ms. Valerie Quioc Lim): Bill 172 was March 20, 2014.

Mr. Mike Colle: And 166?

The Clerk of the Committee (Ms. Valerie Quioc Lim): March 6, 2014.

Mr. Mike Colle: March 6. Yes. That was usually the way things were done, I think—a chronological reference to the committee. So all of a sudden, the subcommittee report, to my astonishment, has bumped 172 ahead of 166.

We had talked extensively about the urgency of 166. We have had many members of the community who were interested in 166, to amend the City of Toronto Act—they have been here at many of our meetings. We discussed 166 and the need to bring it forward, because all it is is enabling legislation that goes back to the city of Toronto for them to debate.

Yet all of a sudden, I find, to my astonishment, that the subcommittee report basically doesn't even put 166 in context and throws in 172. I just find that to be a real abuse of process. We usually go chronologically, and one from each party, which we agree to.

I find nothing wrong with 172 following 166, but to basically not even refer to a date for 166 in the subcommittee report, and then to push 172 ahead, when it was not to be before this committee until two or three weeks later, I think, is really astonishing. Where that came from, and the rationale behind this, is amazing to me.

The Chair (Mr. Ernie Hardeman): Further debate? Ms. Forster.

Ms. Cindy Forster: Thank you. I'd like to know, actually, when Bill 137 and Bill 142 were referred to committee.

The Clerk of the Committee (Ms. Valerie Quioc Lim): Bill 137 was referred to the committee on December 12.

Ms. Cindy Forster: And Bill 104?

The Clerk of the Committee (Ms. Valerie Quioc Lim): Bill 104: December 5.

Ms. Cindy Forster: And 142?

The Clerk of the Committee (Ms. Valerie Quioc Lim): Bill 142: February 20, 2014.

Ms. Cindy Forster: Mr. Colle's argument does not hold water, because there are other bills there that were certainly referred to this committee far sooner than Bill 166 and Bill 172.

I wasn't at the last subcommittee meeting. However, the information that I got from our member who was here was that all the parties agreed. If the Liberals say they didn't agree, I think everyone who is here today needs to know that they certainly didn't move forward Bill 166 at that meeting, to follow next.

We respect the subcommittee's decision, and we're willing to accommodate and support that Bill 166 follow Bill 172.

The Chair (Mr. Ernie Hardeman): Ms. Jaczek.

Ms. Helena Jaczek: I have to refute that totally. I was totally opposed to this particular subcommittee report. We voted on it in subcommittee. I moved 166 up. So your information is incorrect, Ms. Forster.

The Chair (Mr. Ernie Hardeman): Okay. Further discussion on the amendment?

Mr. Mike Colle: Yes.

The Chair (Mr. Ernie Hardeman): Yes, Mr. Colle.

Mr. Mike Colle: Again, we've had discussions about various bills. It's just strange for me, when there was so much public interest displayed in 166 going forward, and all the work that has been done by the city of Toronto and their council and the community. It's of great public interest. They have been here three or four times. I just think it's flabbergasting—whatever the word may be—to all of a sudden see this 172 pushed ahead of a public interest bill that is basically to be discussed so that the city of Toronto can deal with it. I just find it astonishing.

The key thing is that 166 was here before 172. You could have proposed another bill earlier, but you didn't. You put forth this 172 out of the blue.

We said at this committee—I remember—we said, "Bring forward Jerry Ouellette's bill, because it has been there a long time." No; what do I find? Out of the blue, the NDP put forward 172, and they pushed aside—again, as a sitting member of the city of Toronto—they don't come to us for many things, and many of us may not even agree totally with the bill. But we're saying that they have really done a lot of work; they had a lot of meetings and a lot of grassroots involvement. They have just come to Queen's Park on a rare occasion and said, "Just give us a hearing on this." Then all of a sudden, this manoeuvre that the NDP pulls in shoving 172 ahead of 166—it's beyond me, where this comes from.

The Chair (Mr. Ernie Hardeman): Further debate? I just want to caution: We just want to debate the amendment. Incidentally, Mr. Colle, your debate was on the motion, not on the amendment. We want to debate the amendment, which is the one that was put forward by—

Mr. Mike Colle: I'm speaking in favour of the amendment.

1620

The Chair (Mr. Ernie Hardeman): Okay. Ms. Forster?

Ms. Cindy Forster: Thank you, Chair. There's nothing in the rules that says that bills have to be moved in a chronological order, and in fact, that isn't the norm.

The norm is that the committee determines, each time they meet, how and what bills are going to be coming forward. In fact, there are bills from probably the very beginning of this session that have never had a hearing because the government has chosen not to bring them forward.

We support Bill 166, but we also support Bill 172. That is what the committee decided on last week. That's why we're here today, to get on with this, and so I suggest that we move forward.

The Chair (Mr. Ernie Hardeman): Any further debate? This is not an argument. Just state the—

Mr. Mike Colle: On the amendment: The committee did not agree with this. There was a dissension in the subcommittee because the committee, in our discussions, talked about the number of people who have come to this committee asking for 166 to be heard. That's all. Nobody came for 172. Is there anybody here for 172? I've never seen anybody, but people for 166 have been here repeatedly just to be put on the agenda.

You can talk about all the procedures, but generally speaking, this committee is trying to be fair to people who have expressed a democratic interest in discussing this bill and have been talking to MPPs. They've done a lot of work to get on the agenda the city of Toronto. They've come here just for a hearing on it, and then, as I said, if people had come here for 172, maybe we could have had this debate about 172 or 166, but I have never seen anybody ever call my office about 172.

I don't know, Ms. McKenna, if you have, but they've certainly come to my office and called me about 166. Ms. Forster, are they coming to you about 172? Not to mine. That's what I'm saying. Be fair to the people who, in their diligence and hard work, have brought this forward. I'm saying, give them a couple of days of hearings so this bill can be heard and get its due process. That's why I support the amendment by my colleague who voted against this trumped-up motion that basically omits 166 and puts in 172. We should amend it to put 166 as the second bill after 135.

The Chair (Mr. Ernie Hardeman): Okay. Further discussion? Ms. Forster.

Ms. Cindy Forster: One last, Chair. If we move forward with this motion right now and get it out of the way and get our vote done on it, I will move another amendment that will see this whole issue cleared up. Bill 166 would be up for hearings in May. They would have their public hearings. They would have their clause-by-clause and it'll all be done.

The Chair (Mr. Ernie Hardeman): Okay. We can't discuss what will happen after the vote, only before.

Ms. Cindy Forster: No, I know.

The Chair (Mr. Ernie Hardeman): Ms. Gélinas.

M^me^ France Gélinas: I very much want to thank the people who take the opportunity to be involved with what we do at Queen's Park. I represent a riding from northern Ontario. There are issues that are very important to a lot of people in northern Ontario. They just don't live in Toronto, they just cannot come here to be seen, but they are just as important as everybody else. I'm happy that you're engaged, that you live in Toronto and that you're able to come to Queen's Park. If you live in Shining Tree, you won't be here.

What we're talking about is a difference of two weeks.

The Chair (Mr. Ernie Hardeman): Okay. Anything new to add? Yes, Mr. Colle.

Mr. Mike Colle: Again, I think it's a bit condescending. The people in Toronto come from all parts of Toronto. Toronto's a big city. For people to come here—we rarely get this many people for any bill who come from Toronto. So they have shown this interest because at city hall in Toronto, representing 2.5 million people, this has been a bill of great discussion. So to sort of condescendingly say, "Well, you Toronto people can come any time you want. This may be important to you"—everything's important, but this is a rare occasion, when there's a lot of democratic fervour in the city of Toronto.

I don't know if you read the newspapers, but people are very upset at what's happening in terms of the way their council gets elected and the way their mayor gets elected. So these good people, and they represent—many of them have gone out of their way to fight the obstacles at the city of Toronto to look at this change that they're proposing. Then they came here to Queen's Park and were told, "Well, you people in Toronto can come here any time, so we're going to go on with 172"—which I've never heard of anybody advocating for—"and we're going to bump it ahead. You can come later in May," which means basically never. If you're going to do the right thing and listen to people who are here and express interest repeatedly, you've got to do the right thing and put 166 to be heard on April 29. Everything else is just a sham if you don't do that.

The Chair (Mr. Ernie Hardeman): Any further discussion on the bill? Or we'll put the question.

Ms. Cindy Forster: Bill 172—have we heard from people about it? Yes, we have, because it's a bill about youth employment. It's an important bill that affects youth across this province, who have the highest unemployment rates of any age group here in the province. This is a matter of a two-week delay from what the government is looking for; if we move forward, this will all be dealt with by the end of May. Once again, we totally support Bill 166 moving forward, following Bill 172.

The Chair (Mr. Ernie Hardeman): Further discussion?

Ms. Helena Jaczek: Recorded vote.

The Chair (Mr. Ernie Hardeman): A recorded vote has been requested.

Mr. Mike Colle: One last comment.

The Chair (Mr. Ernie Hardeman): Yes?

Mr. Mike Colle: All bills have importance, whether it's 172 or 135. All we're saying, in fairness, is that there's been no one here at this committee three or four times asking to be heard on 172. People have come here and told this committee, "Please give this some consideration." They have expressed this interest. Again, it

reflects a critical issue of representation in the city of Toronto. All they're asking is for a hearing on this.

Again, this thing about, "Well, you'll be heard down the road. We'll bump up 172," I think is really something that almost says to the people who've worked so hard on 166, "We'll deal with you later." But I say we should deal with this on April 29, give them a fair hearing and listen to the people of Toronto who have asked this committee to give them what is their due, because they were referred to this committee before 172 was.

The Chair (Mr. Ernie Hardeman): Okay—

Interjection.

The Chair (Mr. Ernie Hardeman): I hope this is going to add to the discussion, not just to banter back and forth.

Ms. Cindy Forster: I hope so too, Mr. Chair. We are not bumping up Bill 172. Bill 172 was a decision of the subcommittee, last week or the week before, whenever that happened; I think it was last week. In fact, we're ready to move forward here with this vote.

The Chair (Mr. Ernie Hardeman): Any further discussion? If not, a recorded vote has been requested.

Mrs. Jane McKenna: Chair?

The Chair (Mr. Ernie Hardeman): All those—

Ms. Lisa M. Thompson: Ernie?

The Chair (Mr. Ernie Hardeman): Ms. McKenna?

Mrs. Jane McKenna: We'd like to ask for a recess for 20 minutes, please.

The Chair (Mr. Ernie Hardeman): A recess for 20 minutes has been requested.

The committee recessed from 1628 to 1646.

The Chair (Mr. Ernie Hardeman): I call the committee back to order. I have a fast watch.

The vote is on the amendment, and a recorded vote has been requested.

Ayes

Balkissoon, Colle, Dhillon, Jaczek.

Nays

Forster, Gélinas, McKenna, Thompson.

The Chair (Mr. Ernie Hardeman): And the Chair is opposed to the amendment, so the amendment is lost.

Mr. Mike Colle: Shame on the NDP.

The Chair (Mr. Ernie Hardeman): We have another amendment. Ms. Forster?

Ms. Cindy Forster: I move that Bill 166 follow Bill 172 and that public hearings be held on May 13, 2014, and clause-by-clause on May 27, 2014, and that the remainder, 1 to 8, under each of the bills be consistent with what the subcommittee has already agreed to, with the exception, of course, of the dates.

The Chair (Mr. Ernie Hardeman): You've heard the motion. Further debate?

Mr. Mike Colle: I would like the NDP to explain why they're blocking Bill 166, why you're so insistent on putting Bill 172, which came to this committee long after Bill 166 came—you've had members of the public here repeatedly asking for a hearing. You have refused to listen to them.

The ironic thing is this bill is about democratic process. It's about improving democracy in Canada's largest city. The NDP sits there and says, "We don't care what you say in the largest city in Ontario, because you can come here anytime to Queen's Park, so therefore you're not important."

I think you've got to maybe understand what's going on in the city of Toronto. There are a lot of people upset that they're not being heard and they're not being represented properly under the present structure. They're asking for the power to basically look at the structure and see if they can make it better so there's more representative democracy. That's what the people here who represent Bill 166 have asked for.

You may not have been here, but we went through the Mike Harris years when they brought in forced amalgamation; 76% of the people of this city said no to forced amalgamation. The people of Toronto spoke out loudly and clearly: 10,000 of us walked up Yonge Street to basically say that you can't impose forced amalgamation on us, because it takes away our right to decide the future of local democracy. Some 10,000 people were there.

We had a vote in Scarborough, in North York, in the city of Toronto, in Etobicoke, in the city of York and in East York. Ask your member from Beaches–East York what we went through to try to tell that arbitrary government that forced amalgamation was wrong and that it wouldn't work; it wouldn't save any money. And the people were right: With forced amalgamation, the cost of running the city of Toronto has risen and representative democracy has declined, because you've got 2.6 million people—

The Chair (Mr. Ernie Hardeman): If I could just stop you for a moment, the motion we're debating is moving Bill 172 down and Bill 166 forward. If we could stay with the debate on the motion we're debating.

Mr. Mike Colle: Mr. Chairman, 166 is a very significant bill. The tenor of the bill—the purpose of the bill—is improving democracy and representative government in Toronto. I'm putting the context of 166 to the democratic process that they're trying to enhance. It's not just numbers and moving 172 ahead of 166; it's about years of people in Toronto trying to basically make their huge government more representative.

They come here and say, "The Mike Harris government took away representative democracy. Now we want to try to fix it." So they come to Queen's Park, and we say, "We don't want to hear from you." You're going to be—the NDP leading the way to bump their attempt—

The Chair (Mr. Ernie Hardeman): I would point out again, Mr. Colle, that you're speaking to the full motion, not the amendment. The amendment is actually going in the direction you're saying it should be going, which is moving it up the ladder in the original motion.

Mr. Mike Colle: No, no, no. It's not. It's basically still keeping—172 bumps out 166. That is what I'm

speaking to. Bumping 166 is a very sensitive issue, especially in light of the fact that so many people have been here. You've seen them here, day after day, at your committee, Mr. Chairman. They've been—

Ms. Cindy Forster: Chair, he's not speaking to the amendment.

The Chair (Mr. Ernie Hardeman): That's what I'm trying to suggest. That debate may very well be the appropriate debate on the total motion, but this motion is repositioning in the direction you want to reposition it. You want to move it further up than it is.

Mr. Mike Colle: No, no, no. I'm moving it to where it should be. Bill 166 should be next. This motion basically blocks 166 with 172, and I think that's wrong.

The Chair (Mr. Ernie Hardeman): Then my suggestion is that when the motion comes to a vote, you vote against the motion. The motion we're debating is whether we should do this or not do this into the main motion. You can debate the main motion with what you're suggesting now.

Mr. Mike Colle: But I'm also debating this amendment. I think that what it does is block 166 from proceeding by bringing forward this other bill, 172, which I think is a flagrant attempt to block 166 for whatever reasons the NDP have; I don't know. It just blows my mind why they would block a bill that basically discusses improved democratic representation in the city of Toronto.

We as a committee have seen them come here and say, "Please hear us," and we say, "No, we have no time for you, because we've got other more important things," and all of a sudden the NDP pull out 172 and push it aside. I think that pushing aside 166 is significant, because 166, as I said, is not a number. It represents the hours and hours of volunteer, grassroots democracy that's been in play in Toronto for the last couple of years, where people have tried to basically make the system better.

They're not asking you to change the law. They're basically saying, "Give the city of Toronto the right to do this and debate it." It's not even something we're enabling; we're just giving them the power to make the decision. Under the City of Toronto Act, they're supposed to have more power. This basically neuters them again, because we're saying, "We won't even let you discuss it."

It's quite galling for the NDP to tell the people of Toronto, "You can't even discuss Bill 166." That's what you're doing here, and you know that what you're doing—

The Chair (Mr. Ernie Hardeman): Mr. Colle, I would call you to order. The motion that we are debating is, as it says: "I move that Bill 166 follow Bill 172 and that the public hearings be held on May 13 and clause-by-clause on May 27, 2014." That's the issue. And that moves it from number 4 to number 1 in the list of items. That's what changed in the original motion. Your discussion—

Mr. Mike Colle: No, no. Excuse me, Mr. Chair, but it doesn't move it. Number 1 is 135, number 2 is the NDP's 172—

The Chair (Mr. Ernie Hardeman): I'm suggesting that's—

Mr. Mike Colle: It's number 3, which may never see the light of day.

The Chair (Mr. Ernie Hardeman): Mr. Colle, I would point out that that's in the main motion. In the amendment, it is strictly moving it up in the order.

Mr. Mike Colle: Yes, but it still moves it to number 3.

The Chair (Mr. Ernie Hardeman): Yes, but you haven't got an amendment to move it anywhere else. This is an amendment doing what you were asking to do. So I'll just say, your debate—

Mr. Mike Colle: No, I'm asking to move it to number 2. Remember, we lost that—

The Chair (Mr. Ernie Hardeman): As Chair, I'm saying your debate is to the amendment or it's not debate-appropriate.

Mr. Mike Colle: Yes, and I'm still speaking to the amendment that I think is wrong, because of the fact that it doesn't follow the chronological order, because Bill 166 came before Bill 172. Here in the committee of the whole, we talked about the chronological order. The Tories had a bill. The NDP had a bill. We were pushing for 166. So all of a sudden, the chronological order goes out the door, and with this amendment here, they bump—

The Chair (Mr. Ernie Hardeman): I would point out, Mr. Colle—and then we're going to finish the debate on this amendment—that the committee directed the subcommittee to come up with a list and a chronological order of how they wanted the bills to be heard. This is the subcommittee report that we are debating here today. So if you want to speak to the amendment, speak directly to the amendment. If not, then we will have a vote on the amendment and then you can speak to the motion in the whole.

Mr. Mike Colle: Just to the amendment?

The Chair (Mr. Ernie Hardeman): Yes. To the amendment.

Mr. Mike Colle: I was still speaking to the amendment.

The Chair (Mr. Ernie Hardeman): Well, it had better be to the amendment or you're won't still be speaking.

Mr. Mike Colle: Well, we're all talking about democracy right here, aren't we?

Again, if you look at this, by bumping it forward—bumping it back, I should say to May 13, May 27—I mean, we could have an election before then. This is the other thing. There may not even be hearings. There may be nothing here. That's the other game that they're playing, and the public understands that. I just want to make sure that the implication of doing what they're doing by bumping 166, and replacing it with the NDP's 172—they're basically, perhaps, denying the people that have been working on the ranked ballot item the right to ever be heard on this thing. So I just think it's totally wrong, and it's really upsetting to see that the NDP would block 166 when they don't have to. We should

listen to the people who've said, "Please hear us." I'm saying that this motion really blocks 166, sadly.

The Chair (Mr. Ernie Hardeman): Further debate?

Ms. Cindy Forster: In fact, the NDP has not bumped anything. There was a subcommittee report. The subcommittee had a lengthy discussion about these bills. The subcommittee ranked them in order—

Mr. Mike Colle: Not all members—

The Chair (Mr. Ernie Hardeman): Order.

Ms. Cindy Forster: The majority of—the subcommittee ranked them in order. In fact, this bill came up in fourth place, and today, we are making an amendment to move it up to the third spot, following Bill 172.

There are many important bills before this House, at this committee and at many other committees. There's a bill to provide protection for minors participating in amateur sports. There's a bill to amend the Highway Traffic Act to make sure that we have paved shoulders and that people riding bicycles are safe. A lot of these issues are important to many people.

In fact, we're prepared—we moved an amendment. We're supportive of Bill 166. We'd like to get on with this because, of course, as we know, as we continue to debate this, if we get to 6 o'clock, it won't be dealt with today either. So you can filibuster all you want about it—

Mr. Mike Colle: Who's filibustering?

The Chair (Mr. Ernie Hardeman): Order.

Mr. Mike Colle: You are. You're blocking the bill.

The Chair (Mr. Ernie Hardeman): Order.

Ms. Cindy Forster: We're not blocking the bill.

Mr. Mike Colle: You're blocking 166.

Ms. Cindy Forster: Mr. Chair, we're not blocking the bill. In fact, we are supportive of the bill. It's going to be a two-week delay. We'll have public hearings, we'll have clause-by-clause, and we'll move on with this bill.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek.

Ms. Helena Jaczek: I would like to express my concerns about these particular dates that have been chosen: May 13, May 27. As we all know, the possibility of an election is a very real one. It is in the hands of the NDP. We know the Tories are bound to vote against the budget, if they even read it. These dates are very problematic for us, and so I'm speaking against this amendment, because the consideration of these dates may mean that we will never, ever have the possibility of hearing Bill 166 in this committee.

The Chair (Mr. Ernie Hardeman): Okay. If there's no further debate, we'll call the question.

Yes?

M^me^ France Gélinas: It seems like the members from the Liberals know when the budget is going to be tabled and when the vote on it is going to take place. It would be nice if they could share that with us, because then that could certainly influence how I'm going to vote on this. Right now, there is no reason for me to believe that two weeks this way or two weeks that way—if they know when the vote and when the budget's going to be, they ought to share it with us. They cannot continue like this.

The Chair (Mr. Ernie Hardeman): Thank you very much, but that's not directly to the amendment either.

Is there any further debate on the amendment? If not—

Mr. Mike Colle: A 20-minute recess, please.

The Chair (Mr. Ernie Hardeman): A 20-minute recess for the vote? Adjourned for 20 minutes.

The committee recessed from 1701 to 1721.

The Chair (Mr. Ernie Hardeman): The committee will come back to order after the recess. We have an amendment:

"I move that Bill 166 follow Bill 172 and that public hearings be held on May 13, 2014, and clause-by-clause on May 27, 2014."

You have heard the motion. All those in favour? All those opposed? The motion is carried.

Now we debate the report of the subcommittee, as amended. Further discussion? No further discussion.

We'll call the vote. All those in favour of the report, as amended? Opposed? The motion is carried.

Thank you very much. That concludes the subcommittee report.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): There is one other thing that we need to deal with right now. I have here a request. The committee has been receiving documents from the CCAC last week which have been distributed. The documents from the remaining CCACs have also been received by the Clerk. Most of the CCACs have requested if they could be advised if the information will be used publicly so they can let their employees know. Their transmittal letter has been distributed to you for information, and before the Clerk distributes the remaining documents, the committee should decide on how they wish to handle the documents and whether it would accommodate the CCACs' request to keep them confidential. With that, comments?

Ms. Helena Jaczek: I just wanted to clarify because, of course, we received just the covering letters, and they referred to attachments which we did not receive.

M^me^ France Gélinas: Except for the one from the North East that came on a CD.

Ms. Helena Jaczek: Yes, but obviously the Clerk has them and will distribute them.

The Chair (Mr. Ernie Hardeman): Yes. The reason that they weren't distributed is that they wanted this issue to be dealt with before we distributed them. If the answer is that you're not going to keep them secret, they will be distributed anyway.

Ms. Helena Jaczek: Mr. Chair, if I may, I would like to see them before I decide whether they should be kept confidential or whether they can be made public. That's what we've been doing on public accounts. We, as committee members, get to see them. They're held confidential until we make a decision, but I want to see them.

The Chair (Mr. Ernie Hardeman): Okay. There's no problem with doing that if you wish to do that. I'd just ask the committee's indulgence then. We have kind of committed to the CCACs that before we do make them public, we will let them know, so they can—

Ms. Helena Jaczek: Yes, but we need to see them.

The Chair (Mr. Ernie Hardeman): Okay. So after you get them, don't make them public until we've had that opportunity to notify them. Okay?

M^me^ France Gélinas: The only caveat I will say to this is that there are a number of salary disclosures that are on the front page of every newspaper, because the sunshine list has gone out, so whether we quote from—the contracts that they shared with us, nobody else has seen those, but for the salaries, for everybody over $100,000, their salary is already on the public record.

The Chair (Mr. Ernie Hardeman): Yes. The one issue that might come out of that is that the salaries that we are getting are the band. Not everyone who is on the sunshine list is making what the band says they could, so you could see whether they're at the top or the bottom of it. But, again, there's no reason in my mind that you should keep them secret. I think you're right. I found out how much our CCAC director makes as soon as I read the sunshine list.

Okay, that one is dealt with. What was the other one?

I've been asked to deal with the motion that Ms. Gélinas had put forward pursuant to standing order 11(a) on the Standing Committee on Social Policy. Do you want to address that, Ms. Gélinas?

M^me^ France Gélinas: Do I read it? I thought I had read it into the record already.

The Chair (Mr. Ernie Hardeman): Yes, you have read it into the record. We just turn it over to you as the first person to debate it.

M^me^ France Gélinas: All right. Well, my comments will be brief. We've just gone on a tour for the LHINs review. You'll all agree that when people took the time to come and talk to us, a lot of them talked to us about services that were offered by CCACs. This led me to believe that there is a pent-up demand out there to be heard. They saw no other way. They saw us coming into their town and they said, "Well, I have something to say. Here are people from the government. I'm going to let them know what I have to say."

I feel that it's incumbent upon us to give them this opportunity to be heard. Some of what they brought forward I think some of us knew. Some was news, but a lot of it was quite disturbing and pointed to what I would call systemic failings in our home care system that need to be heard.

I was quite happy when the motions from Mrs. Elliott went through at public accounts and that the Auditor General will do a value-for-money audit of CCACs. But the role that we would take on would not go to value for money as much as it would look at: What is the structure, what works, and have we got suggestions to make this work better? Those suggestions could come from policy experts, from people with lived experience, from people working within the CCAC. I'm quite open. But to turn our backs on people who are trying to talk, to connect with us—I would like to give them an opportunity to be heard.

The Chair (Mr. Ernie Hardeman): I just want to make sure I understand it, as Chair. Is this suggesting that this would be a review after the LHIN review, or is this part of the LHIN review? Where do you fit it in?

M^me^ France Gélinas: It would not be connected to the LHINs review. The LHINs review would take its course.

The Chair (Mr. Ernie Hardeman): So this would be after the LHIN review was completed.

M^me^ France Gélinas: It could be. We can decide together the timing. I'm not married to the timing. The motion I'm putting forward is more of a motion as to, did my colleagues feel the way I did, that there are people out there who want to be heard? If we don't give them this opportunity to be heard, I think we would be failing in what we had to do.

We heard a lot about CCACs in our travels, and we were studying the LHINs. That tells me that there are a number of people that need to be heard. I think we could give them an opportunity to be heard and, from this, make some recommendations to make things better.

The Chair (Mr. Ernie Hardeman): Okay. Yes, Ms. Jaczek.

Ms. Helena Jaczek: I guess my question was similar to yours, actually, Chair. I think that certainly as part of the review of LHSIA, we have heard a lot about CCACs, and we probably need to hear more, such as some of the correspondence that we've requested as relates to compensation. So we're getting pieces of it as part of the LHIN review.

I guess I was, again, going to say, in terms of the practicality, that Mondays are for the LHSIA review. Tuesdays are now going to be busy up until, hopefully, May 27. So it was a question of not diverting focus. I was thinking, as I read what you had here, that we might be able—and I don't think there is anything that would preclude us, in terms of the mandate of the LHSIA review, from calling more witnesses or inviting more to address CCAC issues. So I just put that forward for your consideration.

As part of a LHSIA review—what we have heard is that the CCAC piece is something that needs to be really delved into. I'm just wondering if we necessarily need to have a separate process. I think it might be more useful to get at the issues that your motion suggests, because we have until the end of 2014—we hope—to complete that review. So I just put that out.

The Chair (Mr. Ernie Hardeman): Yes, Ms. Gélinas.

M^me^ France Gélinas: I would be open to something like this if everybody agrees that, in the course of doing our work, we would pay special attention, under the LHSIA review, to improving CCACs at the same time. Does everybody agree?

The Chair (Mr. Ernie Hardeman): From the Chair's perspective, it's quite possible that in fact, because of the

LHIN review—and we've heard a lot about the CCACs—the committee could decide to do, shall we say, a sub-review, because the impact of what the decisions on the LHIN review will be is greatly related to what the CCAC review would come up with. If you look at the structure and the pay in the CCAC, that could have a large impact on how you deal with that as you relate to how you deal with the whole LHIN situation.

I think we could find a way to just—at this point, it would likely just require doing a request to get more input from CCACs, and advertising that we're looking further into the situation by digging deeper into the CCACs.

M^me^ France Gélinas: I wouldn't mind hearing from the PCs to see if they are agreeable to that. Yes? Okay. I will let my motion stand, as a backup, but for now—

The Chair (Mr. Ernie Hardeman): I would suggest that you don't have to do it as a backup. Actually, we could vote on the motion, because I think the committee could make the decision to do what you're asking, right within the LHIN review.

M^me^ France Gélinas: Is that correct, Clerk?

The Chair (Mr. Ernie Hardeman): Is that possible?

The Clerk of the Committee (Ms. Valerie Quioc Lim): It would still be considered a separate study, so if you would like to—

The Chair (Mr. Ernie Hardeman): They could be done at the same time, though.

The Clerk of the Committee (Ms. Valerie Quioc Lim): At the same time—but my understanding is that you would just like to dig more into CCACs, under the LHIN review, which is from the House. If this motion passes, it would be a separate study.

M^me^ France Gélinas: Okay, I'm going to let my motion stand, not work on it, and just work upon the goodwill around the table. As we do our LHINs review, if questions about CCACs arise, or if the need for more witnesses arises, then we'll work together to get that work done. I'm not going to push the motion that we have in front of us. Just leave it there, though.

The Chair (Mr. Ernie Hardeman): Okay. Very good. With that—

Ms. Helena Jaczek: Chair?

The Chair (Mr. Ernie Hardeman): Yes?

Ms. Helena Jaczek: Could we just confirm that the terms of reference for the LHSIA review would accommodate the opportunity to call witnesses and so on—to perhaps the Clerk?

The Clerk of the Committee (Ms. Valerie Quioc Lim): I will look into that.

The Chair (Mr. Ernie Hardeman): We'll check that for the next meeting.

Ms. Helena Jaczek: I think you would want that assurance.

The Chair (Mr. Ernie Hardeman): Okay, we'll have that information for you for the next meeting.

Anything else? Ms. Gélinas.

M^me^ France Gélinas: I just want everybody to know that I have booked the media studio tomorrow for 4 o'clock. I know, Chair, that you will be tabling the report. If anybody from the committee wants to come, they are welcome to. It will be a short message from me, basically saying that we have written the report with a view of giving answers to the people affected, and that we felt it important for the people of Ontario who were affected, whether directly or indirectly, to have answers as to what went wrong and what we will do so that it never happens again. That's basically my speech for tomorrow. If any of you want to come, you are welcome to. It's at 4 o'clock in the media studio tomorrow.

The Chair (Mr. Ernie Hardeman): Okay; thank you very much. For the committee's information, we will be tabling the report tomorrow.

With that, if there's no other business for the good of Rotary, this committee stands adjourned.

The committee adjourned at 1734.

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ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40e législature

Official Report of Debates (Hansard)

Monday 7 April 2014

Journal des débats (Hansard)

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Standing Committee on Social Policy

Local Health System Integration Act review

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Étude de la Loi sur l'intégration du système de santé local

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Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

Monday 7 April 2014

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Lundi 7 avril 2014

The committee met at 1529 in committee room 1, following a closed session.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): Okay, it looks like Hansard is ready. We're back in open session. We have a motion. Yes, Ms. Elliott?

Mrs. Christine Elliott: Thank you, Chair. I move that the Chair write a letter to the South West LHIN asking them to provide a report to the Standing Committee on Social Policy that includes details pertaining to all costs, including but not limited to design, layout, writing, printing and distribution, of their publication entitled Spring 2014 Community Bulletin: The Activities of Your South West Local Health Integration Network; and

That this report be sent to the committee no later than the day that falls 15 business days after this motion passes.

The Chair (Mr. Ernie Hardeman): You've heard the motion. Discussion? Hearing none—

Mrs. Christine Elliott: If I may, Chair, just by way of explanation: This publication was quite a glossy publication that was included in a regional distribution throughout the South West LHIN area, so we are very concerned about the costs associated with it. I think it's something that this committee should be informed about.

The Chair (Mr. Ernie Hardeman): Okay. Further discussion? If not: All those in favour? Opposed? The motion is carried.

Any further business, for the good of Rotary?

Ms. Cindy Forster: Are we going to find out whether all the other LHINS have the same glossy productions once we find out the costs of this one? It's a good question to ask.

The Chair (Mr. Ernie Hardeman): What was that? What was the question?

Ms. Cindy Forster: Are the other LHINs all putting out a similar production?

The Chair (Mr. Ernie Hardeman): I would expect that most LHINs do put out some type of production like this, but my guess, being in the South West LHIN, is that this seems to be more glossy and more widely distributed than they have been in the past. There seems to be a reason for—

M^me^ France Gélinas: Without making a motion, then, is it reasonable, Chair, that you write to the other LHINs and ask them for what kind of print media they send to which audiences?

The Chair (Mr. Ernie Hardeman): Okay. Yes, Helena?

Ms. Helena Jaczek: Yes. I guess one would want to be fairly specific. I'm not quite sure how you would word that.

Ms. Cindy Forster: Well, we could send them a copy of South West's and ask them if they produce something similar. If they do—

The Chair (Mr. Ernie Hardeman): Yes. We could write, "It has come to our attention that the South West LHIN had a spring bulletin. Do you publish and distribute similar material?" and then ask them for the same thing that we asked in the—

Ms. Helena Jaczek: I think that would be helpful, to be a little more specific.

M^me^ France Gélinas: Good idea.

The Chair (Mr. Ernie Hardeman): Okay?

Ms. Cindy Forster: Great.

The Chair (Mr. Ernie Hardeman): Anything else? If not, the committee is adjourned. Thank you very much for your kind indulgence in putting up with me.

The committee adjourned at 1532.

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Standing Committee on Social Policy

Ryan's Law (Ensuring Asthma Friendly Schools), 2014

Comité permanent de la politique sociale

Loi Ryan de 2014 pour assurer la création d'écoles attentives à l'asthme

Chair: Ernie Hardeman
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Tuesday 8 April 2014

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Mardi 8 avril 2014

The committee met at 1603 in committee room 1.

RYAN'S LAW (ENSURING ASTHMA FRIENDLY SCHOOLS), 2014

LOI RYAN DE 2014 POUR ASSURER LA CRÉATION D'ÉCOLES ATTENTIVES À L'ASTHME

Consideration of the following bill:

Bill 135, An Act to protect pupils with asthma / Projet de loi 135, Loi protégeant les élèves asthmatiques.

The Chair (Mr. Ernie Hardeman): I call the April 8 meeting of the Standing Committee on Social Policy to order. We're here this afternoon to hear public delegations to Bill 135, An Act to protect pupils with asthma.

ONTARIO LUNG ASSOCIATION

MS. SANDRA GIBBONS

The Chair (Mr. Ernie Hardeman): Our first presenter this afternoon, right after my apologies for starting late, is the Ontario Lung Association, Sandra Gibbons.

We welcome you here this afternoon. You'll have 10 minutes to make your presentation, and if we're going to have different speakers, if you would just introduce yourself for Hansard when you start your presentation. You'll have 10 minutes, and then we'll have questions from each caucus to a total of 20 minutes for the presentation.

With that, the next 10 minutes are yours.

Ms. Sandra Gibbons: My name is Sandra Gibbons. I'm Ryan's mum. I just have something here that I need to share. Imagine—

Interjection.

Ms. Sandra Gibbons: Yes, on the video.

Video presentation.

Ms. Sandra Gibbons: To this day, I still don't know exactly why my son suffered such a sudden, severe asthma attack.

Since Ryan's death, I have discovered that the school board in my area has a policy that forbids children from carrying their prescribed medications. This includes the emergency inhalers used by children with asthma.

I know that the staff at the school did everything they could to help Ryan and that they were devastated by what happened, but dealing with the death of your child is more traumatizing than you can imagine. It has helped me through this difficult time by working with my MPP, Jeff Yurek, and the Ontario Lung Association and by being here today to speak of Mr. Yurek's bill to make our schools safer places for children with asthma. This may be able to prevent another family from going through what I have.

As you discuss Ryan's Law, I want you to remember that asthma is a serious lung disease and that an attack can happen at any time and without warning. I want you to remember Ryan and realize just how dangerous an asthma attack can be, and I want to tell everyone involved in caring for children with asthma to pay attention and do everything you can to make their world a place where they can breathe safely and freely.

So when the question is asked, what does Ryan's Law mean to me, I respond with this: Ryan's Law, Bill 135, is to ensure a safe environment for asthmatics at our schools. The individual plan for a pupil with asthma must include details about monitoring, avoidance strategies and appropriate treatment, a readily accessible emergency procedure for the pupil, and details relating to the storage of the pupil's medication. If our schools had the appropriate education and training on how to respond to an asthma emergency and are able to recognize the signs and symptoms of an asthma attack prior to it becoming fatal, this day, October 9, 2012, I believe, would not have turned into a tragic loss of my son's life.

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Ryan's Law will entail individual student emergency plans, which are provided by the parents of the individual student, as every asthmatic pupil is different and not always at the same severity level.

I know that the training and education on asthma will become an asset, considering that one in five children suffers from this lung disease. It is necessary to have an asthma prevention plan for both parents and teachers to become more aware and communicate how to put into action the best way to treat that individual student during school hours. I believe the appropriate information provided from the child's parents and physician is crucial to management and care for that individual student.

I ask that the Legislature pass Ryan's Law so that we can have safer schools for our asthmatic children, better communication, emergency plans, education, response training, and allow students to carry their rescue inhalers on their person.

The Chair (Mr. Ernie Hardeman): Thank you very much. Someone else wishes to speak?

Ms. Carole Madeley: I'm Carol Madeley with the Ontario Lung Association. First, I need to thank Sandra for her very courageous voice on behalf of all children in Ontario who suffer with asthma at school.

The Ontario Lung Association supports Bill 135. The Ontario Lung Association recommends we initiate Ryan's Law for students with asthma, and then broaden it later to include the results in the recommendations from OPHEA based on their needs assessment related to multiple medical conditions. This will ensure a safe school environment for all children living with a chronic disease.

One in five children in Ontario has asthma—20% of our children. Less than 2% suffer from diabetes, anaphylaxis and epilepsy.

Our issue is urgent, and we appeal to you to consider Bill 135.

The Chair (Mr. Ernie Hardeman): You have about a minute and a half left. Any further comment? If not, we thank you very much for your presentation. We will now have about three and half minutes from each caucus. We will start with the official opposition, Jeff Yurek, the sponsor of the bill.

Mr. Jeff Yurek: Thanks, Sandra and Carole, for coming out today. It's very important to hear your voice with regard to Ryan's Law, Bill 135.

Sandra, I want to thank you for being a really strong advocate for children with asthma and for being a voice for your son after he has passed on. Our thoughts and prayers are always with you, every day. I watch your Facebook page continually, and you're quite active in being a strong voice, so please keep it up. Thank you very much.

Carole, I just have a question for you. I know OPHEA has a plan of action going forward, a study, to include other disease states. I think everybody who has even spoken during our debate—that we're all for that in the Legislature, to carry that further. But should Ryan's Law wait until OPHEA comes forward with the other recommendations?

Ms. Carole Madeley: Because we have 20% of our children in Ontario who suffer with asthma and less than 2% who suffer with diabetes, anaphylaxis and epilepsy, I feel that we need to start somewhere. Definitely, with 20% of our children with asthma, we need to start with asthma. So I would like to see us start Ryan's Law with asthma and then broaden it to include the other multiple medical conditions that occur in our children at school, because it is very important that we ensure a safe school environment for all children living with a chronic disease.

Mr. Jeff Yurek: So, just to follow up, going further, if we were to get Ryan's Law passed through committee and passed through the House within the next month—which I would hope for—it's quite possible that we could have children having their asthma inhalers on their person come this September.

Ms. Carole Madeley: Yes.

Mr. Jeff Yurek: Tell me a bit about what happens in September with asthmatics, with regard to exacerbations and such.

Ms. Carole Madeley: There have been several studies, over a long time, which indicate that we have what's called the September spike. Children are heading back to school—some of them sharing viral infections and sniffles; some of them may not have used their medications on a regular basis during their vacation, during the summer—and we have a spike in asthma symptoms in September. This spike has been well documented in research for several years.

Mr. Jeff Yurek: So trying to get this enacted as soon as possible, as early as September, will help alleviate any further—

Ms. Carole Madeley: It certainly will help with the September spike that we see every year. Our emergency departments and our primary care doctors see more children with asthma in September because of the spike.

Mr. Jeff Yurek: Great. I just want to thank you and the lung association for your support of Bill 135. I appreciate your ongoing advocacy for those with asthma.

Ms. Carole Madeley: Thank you very much.

The Chair (Mr. Ernie Hardeman): For the third party, Miss Taylor.

Miss Monique Taylor: Thank you, Sandra, for being here today and for being so brave. As a mother, I can't even imagine—I think that's pretty much enough said.

I just actually have one question of you, Carole. What are the risks of asthma medication if a child was to take too much? What happens? Do you know what I mean? If we're going to allow children to have their puffers—I know it will be a big part on the parents to make sure the child is very disciplined with their medicine, because it's not a toy. But I can just see that child saying, "I got my puffer. I need a puff. I need a puff." What are the side effects of that happening?

Ms. Carole Madeley: I think what is important, first of all, is that when you decide, "Let's have inhalers at school," it's not just a matter of letting children have inhalers at school. There needs to be an entire educational campaign that goes along with, "Let children have their inhalers at school." You need to not only have support from the parents who are on board with it, and education of the parents, but you also need the school environment and the child. So it really does take a partnership to make this happen.

It's important that the child understands the use of their medication.

Miss Monique Taylor: Of course.

Ms. Carole Madeley: A lot of children get a diagnosis of their asthma at a very young age, so you often will see little babies with little masks on their faces getting treatment. Then we switch to puffers with spacing devices. So these children know about their medication. Usually by the time they are school age, they understand their medication.

Why I mention the spacing device is because the puffer itself is not an easy device to use without adding the spacing device. It's a valved holding chamber that we add to the puffer. If it's not taken properly, 95% of the medication will just get shot to the patient's mouth and to the back of their throat. In order to deliver the medication properly and get it down to the airways, children really do need to have this spacing device.

So a child taking a puffer and just shooting it into their mouth—let's say little Johnny picks up the child who has an asthma puffer and shoots it into his mouth. The child will not have proper inhalation technique and will shoot 95% or more of that medication onto their tongue and to the back of their throat, and there's no side effect to that.

I think the concern is not so much overuse of the puffer. I know, for instance, that if an adult takes their puffer and takes too many puffs, it can increase their heart rate. But again, it means that you're using it properly. If the adult shoots most of it into their mouth, it won't increase their heart rate—only if it's taken and inhaled properly.

Miss Monique Taylor: So there isn't—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

Mr. Balkissoon.

Mr. Bas Balkissoon: I want to say, Sandra, thank you very much for being here and sharing your thoughts with us. We do appreciate that you continue the advocacy work on behalf of Ryan. Thank you for being in front of us.

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I have a question of Carole. You mentioned the OPHEA needs assessment, and you also mentioned that you would rather see us proceed immediately rather than wait for that assessment and the recommendations to come out on how we deal with chronic diseases with children in school, especially management and with the school staff and their training and everything else.

Wouldn't it be more appropriate, though, that the government work with the school boards to provide that training once—and that it's broad in scope, extensive, and well understood—rather than embark on a single asthma process now and then have to go back later and do other chronic diseases that are also necessary at this time in the schools, when the government is already working with OPHEA to find that comprehensive process to work with school boards?

Ms. Carole Madeley: I think the answer to that is that it's going to be the complication of trying to teach all of the diseases at once. You're talking about anaphylaxis and diabetes. Diabetes is very different than anaphylaxis, and diabetes is very different than asthma; and epilepsy is very different than diabetes and asthma and anaphylaxis. So they are very important.

Don't get me wrong: I really do believe that we need to have a safe environment for all children with chronic diseases. I definitely believe that. But we need to start somewhere.

We have 20% of our children with asthma. From an educator's perspective—I'm also a certified respiratory educator—it's probably easiest to teach one element at a time. We have several adults living today with chronic—a lot of co-morbidities, and we understand how difficult it is to try and teach people with complex co-morbidities.

Again, I still feel like it's a lot of education all at once, and they're very different diseases with very different needs.

Mr. Bas Balkissoon: But wouldn't you agree with me, though, that a principal at a school, or a school board, having to deal with this more comprehensively and put one plan out there, rather than dealing with a small piece today and another piece tomorrow and another piece next month—it's much more complex to administer than if we have to administer one comprehensive process.

Ms. Carole Madeley: Yes, and good education takes time.

Mr. Bas Balkissoon: Okay, thank you very much. I don't know if my colleagues have questions—

The Chair (Mr. Ernie Hardeman): No. Thank you very much. That concludes the presentation. Sandra, I want to thank you for being here and sharing your story, and I want to thank all the presenters for being here. It will be quite helpful as we move forward with Bill 135.

Ms. Carole Madeley: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you.

ONTARIO PRINCIPALS' COUNCIL

The Chair (Mr. Ernie Hardeman): Our next presentation is the Ontario Principals' Council: Bob Pratt, president.

Thank you very much, Mr. Pratt, for coming in to present to us this afternoon. As with the previous delegation, you will have 10 minutes to make your presentation. After the 10 minutes we'll have questions and comments from all three caucuses, for about three minutes, to use up the 20 minutes. So with that, the floor is yours, sir.

Mr. Bob Pratt: Thank you, Mr. Chair, for allowing us the opportunity to present today. My name is Bob Pratt, and I am the president of the Ontario Principals' Council, OPC. I have been an educator for 34 years, 20 of those as an administrator.

I'd like to thank Ryan's mom, Ms. Gibbons, for sharing her story with us today.

I'm pleased to see a number of MPPs here today whom we have had the opportunity to meet with over the years, through our Principals' Day at Queen's Park advocacy program and through other events.

The Ontario Principals' Council represents almost 5,500 principals and vice-principals in Ontario's public, elementary and secondary schools. We have many years of front-line experience working with students in a variety of situations.

I'd like to thank Mr. Yurek for bringing forward this very important piece of legislation, and for his efforts, through this bill, to prevent another student tragedy from occurring in any school.

We were pleased to have the opportunity to talk with Mr. Yurek before the bill was introduced, and to provide some input on how such a process would work in schools. We've noted that some of our concerns were addressed in the revised bill.

Our students are our kids. We act in loco parentis, which means "in the place of a parent," knowing that parents entrust us with their most valued treasures every day in our care.

Every day, schools deal with the recurring or emergent medical conditions of many of our students. We work with families to ensure that the needs of students are met and that the directions of medical professionals are followed. It's important to have the involvement of a medical practitioner in these situations since we are educators, not doctors. We can work with families to follow instructions, but we need those directions clearly defined by a physician.

Principals and vice-principals support allowing students to carry their asthma medication with them while they're at school if they have parental permission and the approval of their physician to do so. However, we also think that it would be imperative that all students who do decide to carry their asthma medication with them must also have a duplicate current device, such as a puffer or an inhaler, at the school office as a backup to ensure school staff can be ready to assist if it is necessary.

For the safety of students and to make it workable in schools, the individual plan proposed in the legislation that is to be maintained by the principal must be informed and directed by the student's physician and include clear physician direction about how the school should respond in the case of an emergency.

If the Legislature decides to move ahead with this bill, we recommend that the act include a definition of asthma and a requirement that this legislation apply to those students who have been formally diagnosed with asthma as defined in the act by their physician.

Our biggest concern is that, while the intent of this bill is important, it deals with one medical condition: asthma. The reality is that schools are dealing with an increasing number of current and emergent medical illnesses and conditions every day, of which asthma is only one.

We recommend that the Legislature develop a single, overarching piece of legislation that would cover all student medical issues instead of developing separate pieces of legislation for each one. It's not effective, efficient or practical for schools to be expected to follow different guidelines and procedures for different medical conditions. It is definitely not in the best interests of students either.

The safety and well-being of our students is every principal's top priority, but we must ensure that any legislation is workable in schools. By mandating that diagnosis and treatment plans be directed by a medical professional and by putting in place legislation that covers all possible medical conditions, we can achieve that goal.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We will have about three and a half minutes for the third party. Mr. Mantha.

Mr. Michael Mantha: Good day. Thank you for coming in. You talked about a number of current and emergent medical illnesses. Are there any as high as the 20% that have been identified here through asthma?

Mr. Bob Pratt: I'm sorry? Again?

Mr. Michael Mantha: Are there any other illnesses or emergent illnesses that are as high as the 20% that we have through asthma?

Mr. Bob Pratt: I'm not a medical expert, so I'm probably not comfortable to answer that question. We only know what presents itself at the schools.

Mr. Michael Mantha: Okay. I see the challenges that the school might have in regard to preparing teachers, schools, in order to be able to react to all the illnesses or the emerging illnesses. Wouldn't this potentially be a good stepping stone to start with as one step towards others that are coming up and preparing teachers to look at this one, but also going ahead, moving forward? Wouldn't it be good to start with this as a first step and then add on or amend or move towards other legislation to include the other ones that would come in, in order to prepare teachers or, in the schools, to address the illnesses of children?

1630

Mr. Bob Pratt: You ask the question of moving ahead. As I've mentioned before, our suggestion—and when we spoke to Mr. Yurek—is to encourage that single overarching piece of legislation. While we encouraged a very similar approach to Sabrina's Law, with anaphylaxis, there are some subtle differences within there. The challenge at the school level is that even when the policies and procedures are put in place, there are subtle differences.

Our primary goal is to ensure student safety, and that students are dealt with in the most prompt and accurate way possible. But what we don't want to have happen is for someone trying to second-guess which piece of legislation they are following to make sure that they're doing the right thing for that student. When they talk about the training process, to principals and also to teachers, that would be extremely important.

Mr. Michael Mantha: All right. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. Jaczek?

Ms. Helena Jaczek: Yes. Thank you for coming, Mr. Pratt. As the president of the Ontario Principals' Council—we've had Sabrina's Law for a number of years; Ryan's Law is very much modelled, as we know, on Sabrina's Law—how does the Principals' Council ensure uniformity across the province in terms of how school boards approach, shall we say, Sabrina's Law? There has been some inconsistency, perhaps, and I think, going forward, we always want to follow best practice. So what is the mechanism to ensure best practice currently with Sabrina's Law and potentially with Ryan's Law in the future?

Mr. Bob Pratt: The Ontario Principals' Council represents the 31 public school boards, and each of those public school boards has their own individual interpretation or policy or guideline as to how that would be implemented for the anaphylaxis training and/or Ryan's Law training, depending upon how that would work.

Our position is that we represent the principals, but the principals are employed by the individual school boards, and they're obliged to follow the guidelines or the operating procedures of those boards or else they place themselves at risk.

Ms. Helena Jaczek: So there's no overarching Ministry of Education best practice that goes out to the school boards?

Mr. Bob Pratt: I believe that if you follow the legislation, it states that boards "shall" develop a policy. But there are some subtle differences between boards as to what those policies might actually look like.

Ms. Helena Jaczek: Okay. I'd just like to follow up a little bit on Mr. Mantha's point. Carole Madeley made a very strong argument for passing this legislation because of the numbers involved and the potential urgency in terms of next September. As we add potentially other chronic diseases, in terms of an educational point of view, in fact all these diseases are quite different and their treatment plans are different, and this in fact would be preferable: a step-wise approach to extend the legislation. You, as an educator: How do you feel about that argument?

Mr. Bob Pratt: I think the key point to my statement that we made earlier is that schools—the principals partner with the parents for the safety of the child. But the ultimate decision in terms of the diagnosis and the treatment plan lies with the medical professional, and that's the piece that we strongly, strongly support being in place. The principal can hold or can manage the treatment plan, but we can't develop it.

While we're responsible to maintain that plan, we need help. We do not know the depth or the extent of the challenge, and some of our challenges as principals are that parents may overestimate or overextend the diagnosis or the challenge of the child, or they may underestimate or under-present the challenges. We're obliged to do the best possible that we can for the students. So—

The Chair (Mr. Ernie Hardeman): Thank you very much. With that, Mr. Yurek.

Mr. Jeff Yurek: Thank you, Mr. Pratt, for coming in again. I just want to go over—I mean, the government's saying it would be so hard for the principals to enact a new regulation every month. I've been working on Ryan's Law for over a year for one medication. How long do you think it would take for the government to do all their studies, to talk to each association and come to a consensus on a bill to cover all four disease states? How long do you think kids are going to have to wait in our schools to be able to hold their inhalers?

Mr. Bob Pratt: What we're suggesting is that in terms of the policies, with each individual board, that can dictate if the students are allowed or not to carry those inhalers, or their puffers, to school. I don't believe it would require legislation in order to change that. That would be something an individual board might be able to do on their own.

We acknowledge completely—my own daughter has asthma—the challenges that exist with this. We also understand your point exactly: It takes a long time to prepare and to pass a bill. But what we do not want to lose sight of is the fact that Ontario students in Ontario schools do need a single overarching piece of legislation that would cover not only the current, but those emerging conditions that may evolve over time.

Mr. Jeff Yurek: I would agree to that, but I think the overarching thing that we need to be looking at is student safety. The sooner we can get these puffers into our children's hands at school, the sooner they're going to be safer. So I'm going to be a little harsh on this. We need to pass this bill as soon as possible. It's done; it's ready to go.

But I do want to make note: An overarching bill for—diabetes, epilepsy, asthma and anaphylaxis all have different treatment modes to go through. Anaphylaxis can be self-administered, or, if the child has passed out, you can administer it with a teacher. Epilepsy: Most likely, they'll be having a seizure. They'd need rectal drug use. They can't do it themselves. Diabetes: too low blood sugar; they need a glucagon injection. Again, it's going to be up to teachers to probably inject that. Asthma: self-medication—they won't need the teacher's help or the principal's help. All they need is the puffer on their body.

Mr. Bob Pratt: And we said before: We support that students should be able to carry those puffers to school if they have the parents' permission and the physician's approval.

Mr. Jeff Yurek: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation this afternoon. It was a great help to us.

Mr. Bob Pratt: Thank you.

ASTHMA SOCIETY OF CANADA

The Chair (Mr. Ernie Hardeman): Our next presenter is the Asthma Society of Canada: Robert Oliphant, president and chief executive officer, and Noah Farber, director of government relations. Thank you very much, gentlemen, for your presence this afternoon. As with the previous delegations, you will have 10 minutes to make your presentation. You can use any or all of that. At the end of it, we will have questions from each caucus, or questions or comments, to use the other half of the 20-minute presentation.

With that, your 20 minutes start right now.

Mr. Robert Oliphant: Thank you, Mr. Chair, and thank you, members of the committee, for this opportunity to present as you consider Bill 135.

I want to thank you first for your public service. I have been on that side of this kind of table before, and I know

what it's like to consider bills that you might not know very much about and are constantly learning about. So I want thank you for everything that each one of you does for the people of Ontario and particularly for the children of Ontario.

I want to thank the member from Elgin–Middlesex–London as well, particularly for this Bill 135. I think that his professional expertise as a pharmacist as well as his commitment to the well-being of young Ontarians with asthma is very much appreciated by the Asthma Society of Canada. Thank you very much.

I also want to thank Sandra Gibbons and the Ontario Lung Association for their presentation, which really have brought us here today. It is moving, thoughtful and important work that they are doing.

The Asthma Society of Canada has a 40-year history of trying to be the evidence-based scientific and medical group which offers a balanced voice for people with asthma. We are a group that is patient-driven through the National Asthma Patient Alliance and present ideas to industry, to government and to anybody who can make policies that might improve the lives of people with asthma.

As you've heard, asthma is by far the most prevalent chronic illness among children. My remarks are in your packages, so you don't need to remember these numbers, but in 2011, 239,000 children under 10 were diagnosed with asthma. An additional 418,000 children between the ages of 10 and 19 had asthma. Those are diagnosed by physicians, not self-diagnosed. Those are actual diagnoses.

1640

Asthma continues to be the most common reason for hospitalizations and emergency department visits for children in Ontario, with 4,261 children under 10 being hospitalized, and over 1,000 children and youth between 10 and 19 being admitted.

Not only admissions, but over 12,000 children have under the age of 10 have gone to emergency departments in one year, and over 5,000 teenagers in that same period. That is a lot of scared children and worried parents. Children still die of asthma attacks. The most recent figures we have on this is for 2008, but there are 5.4 deaths for every 100,000 cases of asthma and 10 asthma-related deaths per 100,000. On October 9, 2012, Ryan Gibbons was one of those children who died. We believed that that might have been an avoidable death.

I'm sort of like the Hair Club for Men. I'm not only the president; I'm also a client. I have asthma. I have what is called atopic, or allergic, asthma. It's triggered by environment factors like mould, dust mites, pollen and cat dander. My colleague Noah beside me has asthma as well. His is triggered by exercise or physical exertion. But we both maintain control over our asthma by trying to reduce or manage our triggers and also by having access to our medications.

There are two basic types of medications—this is sort of a primer on asthma for you—there are what we call controller medications, which we take in the morning and at night. It's an inhaled corticosteroid that, for lack of a better term, coats our airways so they're less likely to become inflamed. Then we have what are called rescuer medications or reliever medications—often people call them Ventolin—orange puffers and blue puffers. What we're talking about today are blue puffers. That is what we're talking about when, even if you have controlled asthma, you can have an exacerbation because you encounter a trigger you didn't expect, undergo stress or there's something that is happening. So, even though you might be well controlled, you still have an asthma attack. It's like a lung attack. I often describe an asthma attack as feeling like I'm drowning. I can't get air into my body and I can't expel it from my body. The airways inflame, expand and contract so that they're very tiny and you can't push the air in or out. You feel like you're drowning.

What the rescuer inhaler does is it immediately causes the muscles to relax, and then you can get air in. If you can't get to your reliever inhaler you often have a very stressful moment, and stress has been proven to actually increase the level of and heighten the exacerbation. It is a trigger in and of itself.

We currently have no standardized policy in Ontario for access to medications within the schools. Some schools allow children to have their puffers, some boards allow it and some boards don't. Some allow teachers to hold on to it; others require them to be locked up in the principal's office.

In 2010 we did a survey of National Asthma Patient Alliance's parents, many of whom are parents of children with asthma. They told us that access to medications at school for their children was a key policy item for them. They believe very strongly that their children may be at risk due to school policies that don't allow kids to have their medication with them. They further acknowledged that they believe their children, with only one exception, can handle their medication. These are kids who grow up with asthma. They're not late-adult onset. They use spacers when they're very young and their inhaler technique, as Carole Madeley was showing you, is actually quite good—better than mine. Well, mine is pretty good. I sometimes use a spacer myself. But children have the best technique. They know it's medicine. They know it's not a toy. We have never had an experience of a child using it as a toy. We've never had documentation of a child over-inhaling their medications.

Over 97% of parents felt that their children should have access to medications in schools, and we believe that parents know their own children best. They also indicated that it was either "very important" or "important" at that 97% level. They know that their children know how to use inhalers, and they know that they're part of an asthma action plan, worked out and approved by a child's physician. This bill proposes, very easily—it's not difficult—that if a child has the permission of a parent or guardian to carry their puffer and they have a written asthma action plan, signed off and prepared under a physician's care, then they should be able to have their puffer with them, and we agree.

Of course, teacher training is important. They should understand asthma, and this bill envisions that a school has an asthma action plan for itself, about educating teachers, educating the community about asthma, because almost one in five children do have asthma. It's part of their life.

We're also pleased that Bill 135 recognizes that principals have a role in making their schools asthma- and allergy-friendly, monitoring sources of common triggers like mould or dust or pollens, communicating with the school community about asthma, and we think it is now a good and timely bill.

We are going to be suggesting one amendment, and it's in your kits there. We have a concern about a slight ambiguity, and I think the principal was telling us this. In subsection 2(2), paragraph 4, under "Contents of asthma policy," it states, "A requirement that every school principal develop an individual plan for each pupil who has asthma. The plan must be developed under the direction of the pupil's physician."

We actually agree with the principals that they should not be writing these plans. A physician should write these plans, and there's a sample of one in the kits we have given you, which is an asthma action plan. We believe that physicians are responsible for signing off on it, to understand how worsening happens and how medication needs to be changed, but that the principal should simply require both parental permission and a copy of the plan signed off by the physician and have that in their person.

I'm just noting that I wouldn't agree with the principal that you have to have backup medication in the office. Many insurance plans don't cover you to have two puffers at the same time, which is a problem for access to medications.

So we would suggest that the bill be amended, and I hope one of the members will take this on, that that section be changed to a requirement that every school principal receives and holds a physician-approved asthma action plan for each pupil who has asthma.

There is urgency about this bill, and it has to do with the September spike or peak; 20% to 25% of all hospital care for children with asthma happens in a few weeks in September every year, and it's because kids are coming back to school, and schools are risk factors for children with asthma. Kids have been outside playing all summer. They've taken off on a medication vacation, and they haven't been taking their orange puffers, so they're going to need their blue puffers. School is often closed up in the summer. Mould is higher. Asthma triggers are happening. Fall allergy season kicks in right after Labour Day, just when the kids are getting back to school, plus there are more colds and viruses that need to be dealt with.

One last comment, if I may: Other than the member for Oak Ridges–Markham, we're not physicians. You're doing critical work, but you don't often get the chance to save a life as an MPP. Today, you have a chance to save a child's life, and I hope you take it.

The Chair (Mr. Ernie Hardeman): Thank you very much. We now have about three and a half minutes per caucus, and we start with the government side: Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you very much, Mr. Oliphant. Thank you for being here and giving me lesson 101 on asthma. I greatly appreciate it.

You spoke about 2(2)4 specifically, and that was a concern we had originally, because when you create a law, it becomes a law and it puts a responsibility on to the principal, which leaves itself wide open that the principal has taken on a serious responsibility, one that carries a lot of stress on his shoulders. I think your comment that that needs to be reversed is the same as what the principals were saying about it. So, in essence, you do agree with the principals that this particular act that we have in front of us, if we look at it, may require some amendments.

1650

Mr. Robert Oliphant: I agree that there's a slight—I think it's a wording problem as opposed to a substantive problem. I just think it's to clean it up, because we know that asthma action plans are out there. Doctors do them with their patients all the time, and we know that if you've got one, it's better. So the kids are going to have them, and this makes it easy for the principals to incorporate, which also makes, I believe, asthma management different from epilepsy, anaphylaxis or diabetes. We have a different system for the way we deal with asthma worsenings than those other diseases. So this embeds in this bill a way that we are already doing it and that physicians are very familiar with.

Mr. Bas Balkissoon: I don't disagree with you, but seeing that we have many school boards across the province—and as the principal explained, currently we have some inconsistencies—we need to do it right to make sure we're consistent across the system, because it's now a law; it's not a policy. I just want to hear your comments.

Mr. Robert Oliphant: I think this cleans it up. I think it's well done—and the opportunity to applaud the member who brought the bill forward, because we have been at this the whole time this government has been in place and have been unsuccessful at getting this done. This member has brought forward a very important bill that I know the people of Ontario will stand behind. There's a million Ontarians who have asthma, and they're going to care about this bill. So I think that all members from all parties have the opportunity to support it.

Mr. Bas Balkissoon: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you. Mr. Yurek.

Mr. Jeff Yurek: Thank you, Chair. Thanks for your presentation. Just a couple of quick questions: Do you think maybe we should hold back Ryan's Law and wait till the government creates an all-encompassing umbrella for all the disease states?

Mr. Robert Oliphant: I don't think there's anybody in here who doesn't know I'm a supporter of this government. At the same time, I would call upon the Legislature

and members of the Legislature to use their legislative ability to move this quickly.

We can't wait. One death is too many. I honestly believe that the stress of not having a little puffer like this is quite likely going to kill a child this fall, and I think we can stop that in Ontario. We've been after it for years. Absolutely, we support having a chronic illness plan for each chronic illness that affects children in schools: diabetes, epilepsy, anaphylaxis and others, I'm sure.

This is easy to do. This is a relatively common illness, with high capacity for children to—it's self-managed, as you said earlier, and children will actually be able to respect this rule. And I think it will help the other disease groups as we blend those new requirements in over time.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Mr. Mantha.

Mr. Michael Mantha: Thank you so much for your presentation. Actually, I'm sorry; I missed the beginning of your presentation. I went outside to talk to the principal to get some clarification in regard to some of his concerns, which you've clearly answered. Your suggestion to the amendment really would answer the questions that we were talking about outside.

I'm looking at your action plan here. Can you walk me through it?

Mr. Robert Oliphant: Sure. That's one example. There are a variety of asthma action plans. We have them on our website as well. This is a plan that anybody—child or adult with asthma—should have. Usually, we use colours—and I believe the lung association has similar colours—green, yellow and red, and that is when you should take your medications and how you should do it. Right now, I have a cold, so I have used my blue puffer a little bit more than I normally would because I'm prone to bronchitis, and if I can use a reliever quickly, it will actually stop that. So that would be in my yellow zone and it would take my reliever before I had an asthma attack. That's an example of an asthma action plan that you work out with the doctor who says, "What is your normal experience of a cold? What are your normal experiences when you exercise? What is your normal experience of doing that?"

Many children, before they have physical education, should probably take two puffs from their puffer—not all children, because that, again, will depend on the child and whether or not exercise exacerbates their asthma or not. But that's the kind of thing you do. It's green, yellow and red. It's fairly easy, but it's intuitive too. Children know. Children know their bodies, and when you can't breathe, you do something about it.

Mr. Michael Mantha: So is something like this provided to the school or to the parent—

Mr. Robert Oliphant: To the physician. Physicians, often, will have their own design of the asthma action plan. They use ours. They use the lung association's. They've got stuff they take off the Internet from Australia, from the UK. They have one, they sign off on it, give it to the patient, and then the patient would make a copy of it, give it to the principal and say, "Here's my letter from my mom or my dad or my guardian. I have permission to have my puffer. Here's my asthma action plan. File them together so you know that I am mindful of my asthma." Then there's no problem with having, say, a definition of asthma, because you can't get one of these if you don't have asthma.

Mr. Michael Mantha: Your urgency was heard loud and clear. Thank you very much.

Mr. Robert Oliphant: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated and helpful for us.

EPILEPSY ONTARIO

The Chair (Mr. Ernie Hardeman): Our next presentation is Epilepsy Ontario: Rozalyn Werner-Arcé, executive director. Arsee?

Ms. Rozalyn Werner-Arcé: Arcé.

The Chair (Mr. Ernie Hardeman): That's my name, too, only I spell it differently. Welcome.

Ms. Rozalyn Werner-Arcé: Great.

The Chair (Mr. Ernie Hardeman): It's good to have you here this afternoon. You will have 10 minutes to make your presentation, and following that, we'll have 10 minutes of questions and comments from the caucuses. With that, the next 10 minutes are yours.

Ms. Rozalyn Werner-Arcé: Thank you very much. Good afternoon. As mentioned, my name is Rozalyn Werner-Arcé, and I'm the executive director at Epilepsy Ontario. Epilepsy Ontario is a charitable organization dedicated to improving the quality of life for people with epilepsy and to leading societal change through a strong provincial advocacy voice, mobilizing knowledge and building capacity with epilepsy agencies, people with epilepsy, health professionals, researchers, government and community partners. Thank you very much for this opportunity to speak to Bill 135, An Act to protect pupils with asthma.

There are 65,000 Ontarians with epilepsy, 10,000 of whom are children. I'm here today representing a segment of those 10,000 children who, at some point, may require rescue medication to be administered at school.

Epilepsy Ontario acknowledges that, sadly, there is indeed a need to legislate policy so that children with medical conditions like asthma or epilepsy are safe in schools. Epilepsy Ontario supports the intent behind the bill; the protection of children with asthma is something with which no one can argue. Epilepsy Ontario hopes that no other child dies as a result of inadequate response protocols. Children with asthma must be protected, as well as children with other medical conditions, and that is why we are here today: to bring to the committee's attention the need for encompassing legislation for medical conditions such as epilepsy, asthma, anaphylaxis and diabetes.

Epilepsy is one of the most common neurological disorders in childhood. It's characterized by recurrent,

unprovoked seizures. In most cases, a seizure is not a medical emergency. Typically, seizures run their course and end naturally in seconds or a few minutes. However, prolonged seizures that last longer than five minutes or seizures that repeat without recovery in between can indicate a life-threatening situation known as status epilepticus. Prompt administration of an anticonvulsant is the most effective treatment for status epilepticus. The sooner an anticonvulsant is administered, the greater its efficacy in terminating a prolonged seizure. If an episode of status epilepticus is not terminated early, it can result in permanent neurological damage, injury to other organs, or death.

Children and youth with epilepsy who have an increased risk of status epilepticus may be prescribed a rescue medication such as lorazepam or midazolam. This type of medication acts quickly to terminate a seizure and is more effective when administered early, according to the guidelines of the treating health care professional, than if administration is delayed. Prompt treatment can mean the difference between life and death. Another way to think about it: Rescue medications for students with epilepsy are what an EpiPen is to students with severe allergies or what an inhaler is to a student with asthma.

1700

So what's happening in schools today? Well, despite written doctor's orders and parental wishes, staff may, and do, refuse to provide rescue medication for students with epilepsy. To our knowledge, there are only two boards, Halton District School Board and Halton Catholic District School Board, that have developed seizure protocols for children with epilepsy, although we have also recently learned that the Toronto District School Board has started the process for creating a seizure protocol and invited Epilepsy Toronto and Epilepsy Ontario to be part of the process.

What this means, though, is that the initial response a family will see from their child's school when the rescue medication is prescribed is inconsistent across the province. Some parents have been met with support from their principals and teachers. Other families have experienced resistance and unwillingness to administer the medication if the situation arose.

Let me share with you a couple of examples. One family was offered home schooling until a protocol was put in place. The family was then offered an alternative schooling arrangement, which the family refused, as they wanted their child to go to their local school like any other child.

In another, more recent situation, a family is having difficulty getting their school board to agree to administer rescue medication for their son, who is in grade 9. The local epilepsy agency has offered to provide training and education to the school as well as to arrange to have a nurse come in to provide instruction. To date, the school board has refused.

The student has two to three seizures per week and about once a month may need to have a rescue medication administered. At the moment, he has an older sister at the school. She gets called out of class when he has a seizure, and if he needs a rescue medication, she administers it. She then stays with him until he has recovered. This means that she is missing out on instruction every time this happens, and she is going to graduate next year.

Switching schools isn't an option. The school that this student attends provides both technical and academic instruction with an emphasis on job training, and there are no other secondary schools in the area with a similar curriculum. So what is the family to do?

Some families are savvy and know how to navigate the system. Others are connected to local agencies or have networks they can lean on to support them in advocating for their sons and daughters. But in the end, families shouldn't have to do this. They are already tired, stressed and dealing with anxiety. This additional burden can be overwhelming.

Shouldn't school be a place where families can feel that their sons and daughters are safe? Students with epilepsy should have the right to go to school and be safe. Parents should have peace of mind knowing that if a seizure emergency occurs, their child will receive the necessary medication to avoid life-threatening situations. Parents across the province shouldn't have to fight for this. We need legislation that enforces appropriate policies and procedures to ensure that students with epilepsy are protected.

We believe that all-encompassing legislation that includes a number of medical conditions is required. Epilepsy Ontario has met with MPPs from all three parties, and all suggested—and, indeed, indicated their support for—such action.

Epilepsy Ontario was pleased to hear the Minister of Education's statement in the Legislature last Thursday announcing that a review will be undertaken by the Ontario Physical and Health Education Association. This is a good first step, yet there is much more work to be done, and it needs to be done expeditiously.

Epilepsy Ontario is recommending that, based on the outcomes of the OPHEA review, the legislative body put forth an amendment to Bill 3, Sabrina's Law, and/or Bill 135, if it's passed, or draft new legislation to include all those conditions where a child requires rescue medications. We also recommend that the Ministry of Education provide a memorandum to boards to develop protocols similar to anaphylaxis for all conditions that may require emergency or ongoing intervention, and that the Ministries of Education and Health work with district school boards to provide training for staff as per policy/program memorandum 81.

In summary, Epilepsy Ontario welcomes the opportunity to work collaboratively with representatives from other conditions and with government to move this forward swiftly. We are committed to improving the lives of children with epilepsy and their families, and having legislation in place that protects children with medical conditions in school will go a long way to achieving that goal. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We'll now have three and a

half minutes from each caucus, starting with the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thank you for your presentation. I was one of those MPPs you visited, and it was quite a meeting.

I do want to say, I think we should commend the Halton district school boards for their work with health with our students. They were the ones that actually—you could probably mimic what Ryan's Law is with what they had in their school boards for some period of time. They actually did a needs assessment with their schools at the time and found that the biggest problem for children with asthma in our school system was, in fact, access to inhalers. They seem to be above the curve when it comes to where our Legislature needs to be. So I want to commend Halton school boards, and thank you for adding in their reports here. I think that's very beneficial.

I just want to say that hopefully we'll have Bill 135 passed within the next month, and I'm more than willing to help the government, however quick as possible, pass a law regarding epilepsy and diabetes. But I hope you would agree that: Let's get Ryan's Law completed. Let's not wait. Let's get that done and go forward with the epilepsy.

Ms. Rozalyn Werner-Arcé: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. Taylor.

Miss Monique Taylor: Thank you so much for your presentation today and for making sure that you're bringing the epilepsy voice to the table, knowing that it's prevalent and that it's something that needs to be addressed. We all want our children to be safe when they go to school, and we need to find ways to make sure that their health is cared for so that we don't have incidents like this happening.

I think that the training that is going to go into administering the drugs that are necessary for epilepsy is so very different from self-administering a puffer, which is my first thought. If we can get this through and we can easily train people—because, as we've heard, it's the children who are already trained before they come to school to be able to self-administer. That's, I think, the difference of how we move forward.

But, of course, we need to figure out a way how to deal with all situations across the boards, and maybe, quite possibly, putting it back to the principals and what they're saying: that maybe it's not the boards who need to make these decisions; maybe it has to be a ministry decision so it's the same across the province to make sure that all boards have the same rules and that principals then have something solid to follow on.

Thank you so much. I look forward to how we're going to push the envelope further for epilepsy to make sure that our students are safe at school.

Ms. Rozalyn Werner-Arcé: Great. Thank you. If I could just add, there certainly could be a role for regional or district health nurses to come in and be doing that training. That resource is there, and they can come into schools and do it.

Miss Monique Taylor: I remember that we used to have nurses at school.

Ms. Rozalyn Werner-Arcé: Yes, I do too.

Miss Monique Taylor: Yes, they were always very helpful. They would be great in this case. Thank you.

Ms. Rozalyn Werner-Arcé: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you very much for being here and sharing your thoughts with us. I'm looking at your recommendations, and I clearly understand bullet point 1, which is to go back and amend Sabrina's Law and Ryan's Law, when we add epilepsy and diabetes and anything other than that, or draft a complete new piece of legislation that is all-encompassing. But it's your second bullet point—I really want to understand that recommendation that you put in there. Is that something you're looking at as an interim measure? Because it basically says that the Ministry of Education issue a memorandum to all the boards asking them to do certain things, which is a memorandum; it's not law. The boards may accommodate. In saying that, are you aware of any board out there that has what I would call best practice?

Ms. Rozalyn Werner-Arcé: Sure. I mean, we're looking for something stronger than a recommendation to school boards. As I mentioned earlier, it's really inconsistent across school boards, from school to school, quite frankly, about the kind of support that families can expect. An interim measure in having memoranda and reminding school boards that it should be part of their policies would be wonderful. We'd like to see that, but we think there needs to be something stronger behind that.

So, yes, I would absolutely recommend looking at the Halton District School Board and their policy. If I may, one of our volunteers was a superintendent at the Halton District School Board, and she herself, actually, had epilepsy—still does have epilepsy—and was involved in leading the drafting of that policy.

Mr. Bas Balkissoon: Okay. Thank you very much. Thank you for being here.

Ms. Rozalyn Werner-Arcé: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

Ms. Rozalyn Werner-Arcé: Great. Thank you very much.

1710

MS. NICOLA THOMAS

The Chair (Mr. Ernie Hardeman): Our next presenter is Nicola Thomas. Thank you very much for being here this afternoon.

Ms. Nicola Thomas: Thank you.

The Chair (Mr. Ernie Hardeman): As with the previous delegations, you will have 10 minutes to make your presentation. After that, we'll have about three and a half minutes from each caucus to make any questions or comments to your presentation.

With that, the time starts now.

Ms. Nicola Thomas: Thank you very much for the opportunity today to come to speak with you about this very important bill, Ryan's Law. I come to you today as a professor of health science. I hold an academic position with St. Lawrence College, and I am also a certified asthma educator in pediatrics. I have been a pediatric nurse for the past 23 years—hard to believe when I'm only 29.

This is just my presentation outline. I am here today to talk to you a little bit about my support of this legislation and some study results that were part of my thesis work, and to provide you with a little bit of background and context. I'm going to try to do all of that in 10 minutes.

Parental concern of school management practices is the most common cause of anxiety for parents in my clinical practice as a pediatric asthma educator. We have already heard that asthma is the most common disease of childhood, and that is true. It affects 20% of children living in Ontario. We have half a million children currently living with this disease.

We know that the prevalence has been increasing among school-aged children, and that the prevalence has increased dramatically since the 1980s. We also know that the school context is crucial for asthma management practices, because of children spending 30% of their waking hours within the school system, but also, schools are the only institution that can reach almost all children and youth.

We also know that suboptimal practices with asthma management or delays in emergency room treatment result in exacerbation and even death. An Australian study looked at 51 deaths; 68% of those were directly related to inadequate training and assessment. In a US study, also of children's deaths, one third of children's cries for help were ignored as they went into respiratory arrest. The delays in help were that (1) they were not identified as having asthma, and (2) they were having their puffers locked in the office.

We know that the background to this has been long coming. After the death of an adolescent, there was a coroner's inquest and chief medical officer report that deemed that schools needed to be more asthma-friendly. In 2001, the Ministry of Health and Long-Term Care convened an expert panel and working groups to commission and put together an asthma plan of action, which was an evidence-based guideline.

There were 13 initiatives, and one of these was a public health school asthma pilot project. Out of this came a thorough assessment which found that 80% of teachers did not feel comfortable managing asthma in schools, 50% of schools had no procedure to identify, only 44% of students within the five regions—170 public schools—were allowed to carry their puffer on them, and only 54% of schools had a plan for managing worsening asthma.

The public health pilot project ran over a three-year period and was successful in many regards. It was important that education work with health care. We need a multi-level system. It was a dual-pronged approach.

We know that there is support within Ontario education law that outlines that parents should be identifying their children, but that the school is not without responsibility. Despite the availability of resources that came with publications through the public health pilot project, where OPHEA was also involved in the creations of these tools, and although this asthma-friendly school, as outlined by the coroner's inquest and chief medical officer's report—despite this evidence, we have a child who has died.

I'd like to talk a little about what has happened in our region of Ontario. We know that within the two school boards in the southeastern region, none of them had an asthma-friendly school policy that met all the requirements outlined by Ryan's Law. There was no standard procedure or tools to safely manage asthma within the school setting.

We have been told that the boards have said it is the principals who are the gatekeepers of policies and procedures, and they decide how things run in their school. But when asked about asthma management practices in the southeastern part of Ontario, 53% of principals said that only they were responsible, followed by 20% who said no single individual is responsible.

We had a total of 20,000 students within our study, and 647 of them were identified as having asthma; that's a 3.4% prevalence rate, which means we should actually have 4,200 students with asthma that are not being identified. We know that these children are put further at risk not being identified but having no standard process in place.

When asked how asthma was identified within the school boards, it was a realm of all different sorts of responses. When asked later and interviewed, several principals said, "Wow, I was really surprised. I didn't know about her. I really had to hunt to see who had asthma in my school." There was no standard process.

We know that 60% of the school boards within our study did not have training in place to recognize and respond to asthma emergencies and exacerbations. Given the fact that these children are not being identified and the severity of asthma and the potential for death, this is a huge concern.

We know that within school settings, 30% of students did not have an asthma management plan on file, and only 18% of students identified had an asthma management plan on file. These management plans are the staple of education. They are step-by-step to guide and keep kids safe. Only 3% of students who are identified as having asthma within the school said they had a plan, but what about the 17% that have not been identified?

We know that actually in our region, we scored quite high. There was a policy in place for students to be able to carry and self-administer their medication followed by a policy in place to inform students and parents of this policy. But when asked, principals said, "Well, it depends. If children are under grade 7, we keep their puffer for them. We have to determine if they can use it

appropriately." We know that only two schools out of 61 that were surveyed in our region met the asthma-friendly school criteria as outlined by Ryan's Law.

Whereas Ontario was the international leader for anaphylaxis legislation—the US looked to Canada for how to implement anaphylaxis—we know that we're lagging behind on this issue. The US, the UK, Australia and New Zealand all have asthma-friendly legislation in place. Ryan's Law will address all the CMO recommendations from back in 2000, and it does align with best practice. We know that Ryan's Law will foster community partnership and develop healthy public policy. It will allow for the evidence-based tools that were part of the APA, the Asthma Plan of Action, to become standard across Ontario, and it will allow for streamlining of procedures.

Currently, there are too many gaps in service. We are not receiving a passing grade. Children are at risk every day, and I would ask this committee to pass this legislation and move it forward.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We now have three and a half minutes from each party. This one will be started with the third party. Mr. Mantha.

Mr. Michael Mantha: Wow. I've learned more in your presentation than I've probably been exposed to in my entire life.

Why do you think the resistance is there for children having their puffers? I just want to try and understand. We've heard from earlier presenters that this is medication, the child knows how to use this, and there have been no incidents documented where they've actually abused it. Why would there be a resistance to letting kids self-administer their medication?

Ms. Nicola Thomas: In the Asthma Plan of Action, the public health school pilot project that was undertaken by the Ministry of Health, they asked that question on their survey. There were actually letters sent home to parents saying that medicine is not allowed in schools, flat out. There was the perception—and the lack of confidence—that teachers didn't want it because they didn't know how to deal with it. They were lacking in confidence.

We know that children are able to use their medication. I had a six-year-old who I looked after, developed a plan for and worked with her family. She came up one day coughing, and her mom said, "You know, Sabrina"—for lack of a better name—"your asthma is out of control. I can hear you coughing." She said, "Oh, Mom, I'm all over it. I upped my medication. I'm in the yellows on my action plan." So kids are not going around abusing their medications.

Mr. Michael Mantha: I can relate to that because I have my niece who has a vision problem. She has her glasses and, trust me, she broke her $600 pair of glasses, and when she couldn't play her games after that, she stopped breaking them and she cares for them now.

Is it pure ignorance that people don't understand or aren't prepared or educated to having kids administer their own medication?

Ms. Nicola Thomas: I think that is maybe part of the issue. The other part is that there is a belief out there that asthma is benign: "Ah, you have asthma? Sit on the bench, wheeze a little bit and you'll be fine tomorrow." There is this perception that you cannot die from asthma, and we know that that is not the case.

Mr. Michael Mantha: What are the chances—I don't want to steal your work—of getting an executive presentation of that report, just so I can have it for my own information?

Ms. Nicola Thomas: We can talk about that.

Mr. Michael Mantha: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you—

Ms. Nicola Thomas: Oh, can I just—the other reason is that the principal will decide how asthma is managed in the school. If the principal decides that a puffer is the same as oral medication, it is confiscated and locked in the drawer. That was the other reason.

The Chair (Mr. Ernie Hardeman): Okay. The government, Mr. Balkissoon?

Mr. Bas Balkissoon: Thank you, Mr. Chair. I really don't have any significant question. I just want to thank you for taking the time to come out and share with us all your research so that we can better understand the problem.

Ms. Nicola Thomas: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Nothing more? Mr. Yurek.

Mr. Jeff Yurek: Thanks for your presentation. You can't go yet.

Ms. Nicola Thomas: Okay.

Mr. Jeff Yurek: It was very informative. What I found very interesting is that the government of Ontario, whichever party is in charge, has been studying this since 1999. Do you think 15 years of study is about enough time?

Ms. Nicola Thomas: Yes. I think we need to move forward on this. All the states in the US, as of 2011, have legislation in place to protect children in the schools. The reason why is because a child died and there was a lawsuit.

Mr. Jeff Yurek: Would you think that we should go forward, pass Ryan's Law, get it into our school system, and then let OPHEA take the money they've got to study the issue and put it towards epilepsy and diabetes so they'd have more resources to study those?

Ms. Nicola Thomas: I fully agree. There has been a comprehensive assessment of asthma management practices through the APA. I think that September is coming and we need to move this legislation through. This is a very important issue.

Mr. Jeff Yurek: I thank you for your knowledge and your leadership. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It will be helpful as we consider the bill.

Ms. Nicola Thomas: Could I just—I'm sorry, Mr. Chair.

The Chair (Mr. Ernie Hardeman): Yes.

Ms. Nicola Thomas: In the packages from the Ontario Lung Association, there is a student management plan which was developed as part of the APA. It's specifically for children in schools. It outlines what to do in the event of an exacerbation and when 911 needs to be called.

The Chair (Mr. Ernie Hardeman): Thank you very much.

For the committee's information, our next delegation is not yet here. Because everybody was so distinct with their questions today, they didn't use all their time. So we just have to wait 10 minutes to make sure—waiting for our last delegation. The committee will recess for 10 minutes.

The committee recessed from 1724 to 1737.

ONTARIO PHYSICAL AND HEALTH EDUCATION ASSOCIATION

The Chair (Mr. Ernie Hardeman): I call the committee meeting back to order. Our presenter has arrived. The next presenter is the Ontario Physical and Health Education Association: Chris Markham, executive director and chief executive officer. Mr. Markham, welcome, and thank you very much for taking time to come here and talk to us today. You will have 10 minutes to make a presentation. Following that 10 minutes, we will have three and a half minutes per caucus to ask questions or comments about your presentation. With that, your 10 minutes is starting right now.

Mr. Chris Markham: Thank you very much. As you had mentioned, my name is Chris Markham, and I'm the executive director and CEO of OPHEA. Today, I'm tabling OPHEA's position with regard to Bill 135. I'll just put on the table that OPHEA believes that Bill 135 does not go far enough.

A bit about OPHEA: Since 1921, OPHEA has been working to support the health and learning of children and youth across the province of Ontario. As you may be aware, OPHEA is a not-for-profit organization that is led by the vision that all kids in the province of Ontario will value and enjoy the lifelong benefits of healthy, active living. As an organization, we work with all 5,000 schools across the province of Ontario, all 72 school boards, 36 public health units, and we work in both English and French on a number of healthy, active living initiatives.

Our direct connection to asthma has been made through our connection with the Asthma Plan of Action, through the School-Based Approaches to Asthma project, as well as the role of provincial coordinator for the Public Health School Asthma Program. Over this period—and this has been a 10-year period that we've worked on this—we have worked together with key partners across the province on the development of programs, services and resources designed to increase the skill and the knowledge of child care providers, administrators, educators and school staff about asthma management in schools.

As it relates to Bill 135 directly, we are absolutely—and I would say this as a parent as well—devastated, saddened by the death of Ryan Gibbons. We completely applaud Sandra Gibbons's courage, passion and drive to move things forward to help other children. However, it is still OPHEA's position that we do not think that Bill 135 goes far enough in protecting our kids.

We know that one in five students in Ontario has asthma and that schools play a very important role in terms of managing this condition. We also appreciate, given that we work with all school boards and schools across the province of Ontario, that there are a number of other medical conditions that exist in Ontario schools, such as anaphylaxis, type 1 diabetes, epilepsy and more. The incidence of those medical conditions within school environments is staggering.

The government has passed legislation in the past to ensure that all school boards have policies and/or procedures in place to address anaphylaxis through Sabrina's Law. However, the outlook for developing legislation for every medical condition is not only impractical but extremely unlikely and unworkable within the school environment.

A comprehensive approach—and this is our approach—to the management of multiple medical conditions would be much less onerous for school boards and schools across the province of Ontario and consistent with Ontario's framework for preventing and managing chronic disease.

That's the advice we have provided the government in general. We have met with MPP Yurek, and I applaud his efforts to move things forward. We have also written a letter to the Minister of Education on January 24, and that has been circulated as well, along with multiple education partners—and the list is on the letter. We have written to the Ministry of Education asking for the government to take a comprehensive approach to the management of multiple medical conditions so that all students with medical conditions can be protected. I have provided a copy of that letter, and that's with you.

Very quickly with respect to why a comprehensive approach to the management of multiple medical conditions, we have been advocating for an emergency response policy and implementation plan that ensures schools are appropriately equipped to respond in the case of medical emergencies for multiple conditions. We've been doing this since 2013, when we submitted a proposal to the Ministry of Education, based on our perspective of the Ontario education landscape, calling for a needs assessment.

Through our work with the public health school asthma project—and again, this is something that we've been working on with the Ministry of Health and Long-Term Care for 10 years—we have raised some preliminary questions with school boards and school board leaders across the province which uncovered that not many have the policies or tools in place to support asthma management, or the management of other medical conditions, for that matter. The experience of the

Public Health School Asthma Program over the past 10 years for OPHEA has indicated to us that school boards lack the capacity to address asthma as a stand-alone issue.

In conclusion, we're pleased that the Ministry of Education is supporting OPHEA by providing OPHEA with the resources to conduct a needs assessment. The purpose of this needs assessment is to gain an understanding of the current policies and practices, medical conditions that school boards currently address, as well as available resources, partnerships and implementation support. We will also specifically be looking at and reviewing how schools deal with the four major prevalent medical conditions, including asthma, anaphylaxis, diabetes and seizure disorders, including epilepsy. We will as well be looking at the identification of other prevalent medical conditions within schools. OPHEA will working with our health and education partners and will submit our recommendations on next steps to the Ministry of Education in January 2015.

We are, as an organization, concerned that there are many incidents of medical conditions that currently exist within the school environment. We feel that stand-alone legislation for every single medical condition is impractical and it's unworkable. Our goal, much like I'm sure everyone else's, is to protect as many students as possible.

That concludes my remarks for today.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We now will have questions from the caucuses. We'll start with the government. Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you very much, Mr. Markham, for being here. Just a quick question: When Sabrina's Law was passed by the Legislature, how long did it take your support organizations here to put in place something in the school boards?

Mr. Chris Markham: I will ask for a point of clarification on that as well. As an organization, we do not have any specific mandate to influence school boards per se.

Mr. Bas Balkissoon: No, that's not my question.

Mr. Chris Markham: Okay.

Mr. Bas Balkissoon: As an organization, you're working with most of the partners in the school board. So I'm just asking: Are you aware of how long it took them to roll out Sabrina's Law?

Mr. Chris Markham: The specific school boards?

Mr. Bas Balkissoon: Yes.

Mr. Chris Markham: I can't say for sure, but I know that on policies that are extremely important to the health and well-being of children and youth and students, it's fairly quick. But again, the Ministry of Education could speak to that better. And by "fairly quick," I mean that if the ministry says something should be set up by a certain point, that's when school boards set things up.

Mr. Bas Balkissoon: Okay. Based on your letter and your presentation, you're basically saying that your work will not be completed until January 2015.

Mr. Chris Markham: The needs assessment, the report, is due to the Ministry of Education in January 2015.

Mr. Bas Balkissoon: One of the presenters requested an interim solution, until you do your complete job and we pass a comprehensive piece of legislation. Can you give us input? What can be done in the interim? Because there's a lot of concern by the interested parties.

Mr. Chris Markham: I think for an interim solution, there may be opportunities to increase the dialogue with school boards and schools across the province with respect to the management of multiple conditions. However, as I'm sure you're well aware, there are large school boards, there are small school boards and there's everything in between, and the number of school boards need different levels of support. Some of the larger school boards may be able to react immediately. There are a number of school boards that are also leading, in terms of current practices. So I think one of the things that could be done immediately is just to increase awareness of the fact that multiple medical conditions currently exist within the school environment and let them know that there's a process in place.

Mr. Bas Balkissoon: My colleague has a question for you.

Mr. Mike Colle: Yes. As a recovering asthmatic, I have got a couple of questions. Given all the expertise there is in schools with phys ed, sometimes involvement with public health nurses—the whole thing—it seems beyond my comprehension why there isn't a health plan already in schools to deal with these sudden and very, very precarious health situations. By the way, I was a teacher, too; I've got a bias there. I taught phys ed and history. So I would want to know how to deal with these crisis outbreaks. I would want to know what my protocol should be, and I would hope that the whole staff would be taking one of their professional development days and maybe using it put in a health protocol. I mean, It's not rocket science. It's like—

The Chair (Mr. Ernie Hardeman): That concludes your time.

Mr. Mike Colle: Okay.

The Chair (Mr. Ernie Hardeman): Thank you very much. Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in. Did you have the same dissertation to committee when Sabrina's Law was being discussed?

Mr. Chris Markham: I'm going to say, at that point—I believe it was 2006—I was not in the current role that I am now.

Mr. Jeff Yurek: Did OPHEA?

Mr. Chris Markham: I can tell you off the top of my head: I don't know. I would imagine that as it relates to issues around health and well-being, we try to make our position known. So I would hope we would have.

Mr. Jeff Yurek: I just look at your conclusion and I think it's a great—that "our goal is to protect as many students as possible." But by doing what you're doing, that fact is, you seem to be not protecting any at all. I don't get how not letting Ryan's Law go through so that students have their medication on their person—I don't get how that doesn't make sense to you, and why we'd have to wait till 2015 for a needs assessment, let alone

then to go to the ministry to develop. Going your route, we're three, four years away from protecting our students with asthma, and you're saying that the school doesn't have the capacity to bring that alone. All we're doing is saying that principals have a copy of the doctor's action plan and students have their puffers on their body. You need to explain it to me more. It's just not sinking in.

1750

Mr. Chris Markham: I guess I would suggest to you—what's going to happen in the cases of epilepsy, what's going to happen in the cases of diabetes—

Mr. Jeff Yurek: We're dealing with asthma in Bill 135, so we can talk to Bill 135.

Mr. Chris Markham: No, and I appreciate that.

Mr. Jeff Yurek: I will do an epilepsy one next year if you want. We'll get this done by next spring. Let's do them. Let's get them done.

Mr. Chris Markham: I guess what I'm saying right now is that there's no point in going through multiple years and waiting until incidents happen that are devastating, such as this one, before we decide that schools need a broader, all-encompassing policy or plan to be able to manage multiple conditions.

Mr. Jeff Yurek: I'm not arguing on that point; I agree. However, it seems to me that you don't want Ryan's Law to go forward when we can have this passed and, this September, our kids with asthma can be protected. So we've got a segment protected. With your route, they're not protected. They're not safe in the schools. We're waiting probably four more years, following your—turn around and tell Sandra and explain that to her, because I can't. I tell you, I don't get it.

Mr. Chris Markham: I guess I would challenge you on the four years. Why do you think that?

Mr. Jeff Yurek: Well, it's taken me over a year just to get this far with Ryan's Law. You're just doing a needs assessment. Then you're going to have to do consultations with all the school boards. Then you're going to have to do consultations with the Ministry of Health. Then we're going to have to debate it in the Legislature, and by then, there's probably going to be one election, I believe, and so you're going to have to start all over again. That's why I'm saying "four years."

Let's do it now. Let's do it today. Let's have it in place this September.

The Chair (Mr. Ernie Hardeman): Thank you. The third party: Mr. Mantha.

Mr. Michael Mantha: Your study, basically, going forward, is going to come out in January 2015, which is going to be your needs assessment. Right?

Mr. Chris Markham: Right. That will be the conclusion of the needs assessment. The report recommendations will be provided.

Mr. Michael Mantha: And it has taken us 10 years to get to that point?

Mr. Chris Markham: What I can tell you is that in 2013, we began advocating to the Ministry of Education for this needs assessment. I can't comment on the four years. I can't comment on 10 years. What I can comment on is the fact that we need a broad policy and it does not make sense to me to continue to address these things in isolation.

Mr. Michael Mantha: For me, what I'm having a hard time swallowing here is that we can actually implement a small change here where it may save a life. Yes, I think that everybody in this room agrees with the fact that we need a more comprehensive approach, but we can do something now. I think that's what we really need to focus on. Yes, we need a comprehensive plan for all of the other illnesses; nobody is disputing that fact. But I think that we can all appreciate the fact that we have an opportunity here. This is a small step. I hope to God that we don't lose a life, but it may save a life, and we should be doing that. We should be taking those steps. As representatives in this room of our communities, we should be making sure that we're taking those steps.

Mr. Chris Markham: If I can respond to that point, I don't disagree with you. I guess what I would be frustrated with, as a taxpayer and as somebody who works in the not-for-profit sector and has to work with government a lot—this should have been done a while ago and it shouldn't have been done in a fashion that specifically related just to asthma.

I think, Jeff, when I met with you a while back, you had mentioned as well that, potentially, the health critic was looking at a diabetes one. That's as ridiculous as the conversation we're having now. If politicians, again, understand the fact that it makes sense to do something comprehensive, why couldn't conversations have happened between the health critics and the education critics to be able to make something that's more encompassing? I guess that's where I struggle, because the potential here is—yes, we will move forward with one more issue-specific thing. The government may or may not fall with this election, and then we're going to have to wait for something really bad to happen to address epilepsy or diabetes or a whole host of issues that we don't know are coming up, and that's also not fair to kids.

Mr. Michael Mantha: I agree with you wholeheartedly. It comes down to focus and where our priorities are. You're absolutely right: This is a discussion we should have had a long time ago.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do appreciate you being here.

With that, that concludes our deputations today. I just want to remind the committee that the deadline to file amendments with the committee Clerk is 4 o'clock on Thursday, April 10, 2014. That's the deadline if anyone wants to bring forward amendments to the bill. The next meeting, for clause-by-clause, will be on April 15.

With that, that concludes this afternoon.

The committee adjourned at 1755.

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ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40e législature

Official Report of Debates (Hansard)

Monday 14 April 2014

Journal des débats (Hansard)

Lundi 14 avril 2014

Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur l'intégration du système de santé local

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

Président : Ernie Hardeman
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Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 14 April 2014

Lundi 14 avril 2014

The committee met at 1402 in committee room 1.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): I call the committee on social policy to order.

Interjections.

The Chair (Mr. Ernie Hardeman): If we could have everyone in the room just pay attention a little bit, we can get started here.

It's the April 14 committee on social policy. We're here for the review of the Local Health System Integration Act and the regulations made under it as provided for in section 39 of the act.

DATA AND TECHNOLOGY SOLUTIONS

The Chair (Mr. Ernie Hardeman): First this afternoon, we have a delegation to make a presentation: Data and Technology Solution, Mr. Jeremy Albisser, principal consultant and owner. If you would take a seat there. We thank you very much for coming in to make a presentation this afternoon. You'll have nine minutes to make your presentation. You can use any or all of that time. At the end of that, we'll have three minutes from each caucus to ask questions and to make comments. With that, the floor is yours, sir.

Mr. Jeremy Albisser: Thank you very much, Mr. Chairperson and Vice-Chair. Thank you for the opportunity to come here and speak with you about the Ontario Local Health System Integration Act and its impact on Ontario integrated health service providers.

To give you a little bit of background, for the last 10 years I've been on the front line between the local health integration networks and the integrated health service providers in the rollout of accountability. When the LHINs asked the integrated health service providers to sign accountability agreements, I'm one of a number of people in performance measurement management and accountability that will interpret that legislation, come up with benchmarks, work with communities, hospitals and the LHIN to come up with targets and benchmarks and negotiate funding.

For the last 10 years, Ontario's integrated health service providers have stepped up to the plate. There are over 1,100 community mental health and community support service agencies across this province that have individual boards of directors responsible to their local clients, patients and families. They have stepped up in the form of providing accountability reporting requirements. They have stepped up in the form of providing quality indicators, performance indicators. They have stepped up in the realm of patient and staff satisfaction surveys.

I know that over the last little while you have all been hearing from a number of those community support services and community mental health and addiction organizations here in the province of Ontario. I can tell you from the data point of view, from somebody who's been analyzing this data for a while, their work is spectacular. It is cost-effective. It is well done. These people are engaging their communities, and they are doing great work.

On the flip side, I am going to read the second page here. I will read the interpretation that most of the integrated health service providers have been using for accountability; I know that there have been a lot of questions in this committee about what accountability is.

For health service providers, for people who provide care to patients on a daily basis, accountability to them means "To have in place the tools, mechanisms, processes, checks and reports necessary to ensure that negotiated targets and benchmarks are met in an equitable, patient/family-centric, evidence-and-quality-driven way, which maximizes the cost effectiveness of the resources placed in our care." The resources placed in their care include the people, technology and funding, and these people have stepped up.

The health system transformation over the last 10 years has been a huge burden on these people—administration costs; cost-of-living adjustments—and the work that they have done has not been acknowledged to the extent that it should.

I remember that at the beginning of the health system transformation the promise was made that, in the rollout of accountability, if health service providers could meet this definition of accountability, the turnaround would be that the government of Ontario—the Ministry of Health—would address funding gaps, would provide equitable access to dollars to ensure that there are consistent levels of care across the province and to ensure that their staff members are taken care of.

For the last little while we've seen hiring freezes. We've seen wage freezes across all of these sectors that have had an impact on their ability to hire and retain

staff. It's had an impact on their ability to prepare for the oncoming seniors crisis. The aging workforce in the community sector and the hospital sector—across all of these sectors—is significantly higher than in the private sector, and there has not been—and is not—the preparedness for the oncoming retirement and increase in boomer health service needs.

I've included a bunch of recommendations that are broad, broadly speaking. You can read through them. Suffice it to say that I've worked and done analysis for the Auditor General for the last SE and accord fundings. I did analysis for the waiting-at-home program for the Mississauga Halton Community Care Access Centre. I've done analysis on program after program in the province of Ontario, and I can tell you that the Ontario health service providers have stepped up. It's time for the Ontario Legislature to step up with the funding that was promised at the beginning of accountability.

I welcome any questions that anybody has.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much for your presentation. With that, we will start with the official opposition with questions.

Mrs. Jane McKenna: Thank you so much for coming in here today. You've said numerous times in your presentation there that they have stepped up to the accountability. Can you be specific in what they've done to step up?

Mr. Jeremy Albisser: To take one example, when I was working at the Mississauga Halton Community Care Access Centre, the CCAC had been in a deficit position the previous year. The CCAC was placed into what's called a performance improvement plan, and I, as the manager of decision support and research, was responsible for providing our local health integration network with all of the data necessary to ensure that we were meeting the targets of that performance improvement plan.

About 700 indicators were reported over the course of a year. To put that in perspective, the World Bank recently recommended that 600 indicators for managing an entire country's health system is too many, so a CCAC that steps up with 700 data points on a yearly basis, meeting all of their targets and meeting their performance, for example, is them stepping up.

In addition, I don't know how many people have actually read a multi-sector accountability agreement, but there are requirements for patient satisfaction surveys and staff surveys. A large chunk of those surveys are not only done; they're available on each one of the individual health service provider's websites, along with all of their accountability agreements. I would remind you that they've done all of this, in large part, without any increases to administration funding or even increases to base funding.

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Mrs. Jane McKenna: So do you think more money means better service?

Mr. Jeremy Albisser: No. What I think is that for the last 10 years no money has meant decreases in funding with not significant decreases in service. So a service provider that has a zero budget increase over five or 10 years and is still servicing the same number of patients has in fact improved their efficiency significantly.

Mrs. Jane McKenna: You talked numerous times here about evidence-based outcomes. Then you've said here you've got performance improvement plans that are measured. Can we see those measurements?

Mr. Jeremy Albisser: If you go to each one of the integrated health service providers, almost all of them are required to and do post them on their own websites. It is a bit of a hassle to go to each one of the service providers, but there are a lot of service providers out there, so they tend to handle it on an individual basis. Remember, each one of these agencies has an individual board of directors that's responsible to their members, or in large part responsible to their members, and they are very responsive to their members. So the documents are really available to their own members, as opposed to people all the way up in the ministry or in the government. But they are available.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time. The third party?

Ms. Cindy Forster: Just a couple of questions. I kind of flipped through the first few pages, and if I look at page 3 of 14, it says that in 2012, 65-plus is at 15%, and that it will be at 17% by 2020.

Mr. Jeremy Albisser: Yes, and 20% by 2027.

Ms. Cindy Forster: But when I actually go to the next page, 2013, it says that 65-plus is at 22% already.

Mr. Jeremy Albisser: I'm sorry. This should be 2031.

Ms. Cindy Forster: Oh, 2031. Okay.

Mr. Jeremy Albisser: Yes, 2031. Thank you for bringing that to my attention. I apologize for the mistake.

The other important thing to remember is the X axis there, with the adults, the 15 to 65. There's a significant drop in the available workforce, both for regular health service providers but also in the volunteer community. So if we look at the huge number of volunteer hours that are put in by health service providers, by Meals on Wheels, by delivery people, as the population ages we either need to significantly engage the retired community so they are supporting each other as the senior population becomes older and older or we're going to have significant increases in health care costs.

Ms. Cindy Forster: So you actually are a private company?

Mr. Jeremy Albisser: I'm an individual.

Ms. Cindy Forster: And you actually have done work for the Auditor General in addition to doing work for, I'm assuming, a number of CCACs and LHINs. How many of the 1,100 agencies that you mentioned have you actually done work for, say, in the last five years?

Mr. Jeremy Albisser: I had a two-year contract with the community care eHealth in the rollout of the MIS/OHRS reporting system for community mental health and addictions.

Ms. Cindy Forster: Yes.

Mr. Jeremy Albisser: And during that time was the audit by the Auditor General on the SE and accord funding rollouts that had happened previously. So I've actually analyzed all 400 of the community organizations for the government of Ontario.

Over the last five years, it would be the CCAC, 11 adult day programs, and Baycrest, which I was at for about—

Ms. Cindy Forster: And Baycrest? And what about the LHINs?

Mr. Jeremy Albisser: I've never worked for a LHIN, though I was the last information management analyst in three of the regional offices before they closed down and became the LHINs.

Ms. Cindy Forster: When they were the district health councils?

Mr. Jeremy Albisser: Well, there you had the regional offices and the district health councils. I was in one of the regional offices. The regional office had a staff of about 150 people at its peak, and they would have been replaced by one LHIN.

Ms. Cindy Forster: And what about community health centres and family health teams? Have you done work for them as well?

Mr. Jeremy Albisser: Not directly, no.

Ms. Cindy Forster: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek?

Ms. Helena Jaczek: Thank you for coming in.

I'm looking at your recommendations on page 12 of 14. I wonder if you could just tell us a little bit more. You say, "If scarcity breeds innovation, then it's time to commercialize and take advantage of those innovations by providing funding for the adoption, use and sharing of technology and innovation using decisions made at the local level, i.e. BSO." Is that Behavioural Supports Ontario?

Mr. Jeremy Albisser: Yes, when I was at Baycrest, I was on the Behavioural Supports Ontario project, and it's a great idea. We have a significant existing problem and an oncoming problem with dementia and brain degenerative disorders. The problem is, these are really high-resource people that, truthfully, nobody in the world knows what to do with. Behavioural Supports Ontario was a great way of pulling together people from across the province, letting them try entirely different things, and then putting the mechanism in place for them to share it amongst themselves and build on best practices.

This is the kind of program that should be repeated over and over in Ontario for assertive community treatment teams, for addiction programs, for just about anything. If you don't have a solution to a problem, it's a great way to get a lot of people at the table to come up with solutions to the problem.

Ms. Helena Jaczek: In other words, you see the BSO as sort of a model that could be used in other program delivery areas?

Mr. Jeremy Albisser: And internationally. I think that it's one of the many things that—and this goes back to what I was speaking about when it comes to innovation. Ontario is actually leaps and bounds ahead of most other jurisdictions when it comes to assessing, managing and looking at the data for our health system. There is more data available here than there is anywhere else. We don't necessarily use it downstream as much as we do—the accountability all rolls up. Very little of the data comes back down, which is a big problem for community organizations and LHINs, who have limited resources to do detailed analysis, which they need to do. But still, there's more data available here, and the model that we've rolled out where—theoretically, at the board of directors level in the community, funding decisions could be made on things like purchasing iPads, purchasing technology, implementing technology.

For the last 10 years, there has been no innovation in this. The charities will raise their own money. Because it's their own money, they'll make their own decisions. Doing that at a local level really has allowed them to come up with the best practices. What we need to do is figure out how to take those best practices, roll them out to much of Ontario, and then the rest of the world, because they don't know what they're doing either—no better than we do.

The Chair (Mr. Ernie Hardeman): That does conclude the time. We thank you very much for being with us this afternoon to give us insight into your business.

COMMITTEE BUSINESS

The Chair (Mr. Ernie Hardeman): That's the only delegation we had this afternoon, so with the committee's permission, we'll go in camera to discuss some further report writing issues and other policies.

Ms. Gélinas.

M^me^ France Gélinas: Before we do that, I don't know if we have to do—remember, I had put a motion forward so that we include a review of community care access centres. We had talked about this in camera. Is it time for me to bring it out in non-camera?

The Chair (Mr. Ernie Hardeman): Yes, that's fine. We could do that first, if you'd like. There are some challenges since that one has come forward as to—not that the motion is out of order, but to the people higher up, shall we say, the people in the know, there's a challenge of adding it to that which the House asked the committee to study. The committee has all the rights and privileges to study whatever they wish, but it would be inappropriate to make it part of this report. So we can do this motion and then do it subsequent to the review of the LHINs, or you can, at this point, do as you did before and just leave it in abeyance until—we could still look at some of the parameters of the CCACs that reflect how the LHIN works, but not as part of the total LHIN study. With that, the floor is yours.

M^me^ France Gélinas: I would say I'm quite comfortable with where we have landed, as in, we all agree that through the hearings we heard—many people came forward to us talking not specifically about the LHINs

but talking about CCACs in their jurisdiction. We've all agreed that we will pay attention to what those Ontarians have said to us in order to try to make the system better and that the mandate of this committee is wide enough that we all feel that there would be some recommendations that will be specifically targeted at CCACs—or they could be; we haven't come to recommendations. There could be recommendations.

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As long as the door stays open so that the people who have come to us are respected in the fact that we've heard them, that we will deal with the challenges they have presented to us and that the door is open to this committee to make recommendations that target the community care access centres, then I am quite willing and comfortable just letting this motion sit. I'm not going to pursue it at this point.

We will continue to do our work with the LHIN review as long as it has been confirmed to me that our mandate is broad enough that if we want to address some of the issues that were brought forward, we'll be at liberty to do this, if we all agree.

The Chair (Mr. Ernie Hardeman): Yes, and I guess I'll just put it to the committee. I think that it's appropriate to do as we've been doing. I don't think that the committee, so far, in what we've heard and discussed about the CCACs, would in any way be an impediment to meeting the challenges that were presented to us when the House told us what to do.

Also, to deal with it when we get to that point, I think the question would then be, when we've heard all that we need to hear as it reflects the LHINs, whether a report on that would require a different report and a different process beyond that. You might want to make more recommendations than what you've heard, than what this report would enable. The committee does have a right at any time to call what it is they wish to review and report on to the House, so I think your suggestion would be quite appropriate.

M^me^ France Gélinas: Okay. I'm quite comfortable continuing on the work that we have done.

The Chair (Mr. Ernie Hardeman): Okay. Are there any further comments on that?

Mr. Mike Colle: Yes. I guess we've just got to be clear on that, in that—will we have an addendum or a complementary report that goes as an adjunct to the LHIN report?

M^me^ France Gélinas: No.

Mr. Mike Colle: No? So it all goes—

The Chair (Mr. Ernie Hardeman): No. If, at the end of the process, the committee feels that they wish to address the issues about the CCACs apart from the LHINs, it will require a study and a complete report on the CCACs. That does not mean you cannot look at some of the issues, as we've been doing, about the CCACs—

Mr. Mike Colle: Within our report.

The Chair (Mr. Ernie Hardeman): —within the report. But in order to really deal with them, you would require a totally independent report.

Ms. Helena Jaczek: Exactly. I was just going to say, further to that, that I don't see that there's anything to stop us from making comments on what we heard and the fact that, obviously, CCACs are agencies with which the LHINs have service accountability agreements. Clearly, we can make comment on that. But they are governed under a different act, and I think that's really important. Amendments, if there were to be any to the CCAC act, would have to be in a separate report, but we can always get to that point at some future date.

The Chair (Mr. Ernie Hardeman): Personally, I had a little concern about what we heard at the hearings, the amalgamation of the two boards. I don't know which report that would fit in, because there is no study presently available to us to study either the LHINs or the CCACs for that recommendation, and yet I do believe that at some point the committee should be able to make such a recommendation or recommend against it. That's why I think it's helpful to leave the discussion of how we deal with that second report until we finish this one.

Yes, Ms. Forster?

Ms. Cindy Forster: Yes. My question is to you, Chair. You said at the beginning that some other issues have come to light that may impact our motion. Could you provide a little more detail, or is the detail only that the CCACs fall under different legislation?

The Chair (Mr. Ernie Hardeman): We checked with the Clerks' department, and in fact they believed that the motion to suggest that this could be part of—the motion that we got from the House to review the LHINs, which is a statutory review, does not enable us to add to that. That's why we can study the impacts of what the LHINs are doing, but not study the different things.

The largest consumer of LHIN dollars is the hospitals, so this argument really would become, could we also do a complete review of the hospitals under that direction? And the answer would be no. It's just that we have to keep that in mind, that we're reporting on what the LHINs are doing, and we can look at some of the impacts of what they're doing on the different organizations they're working with.

Ms. Cindy Forster: Well, in some ways, I find that to be very strange. This is the governing body that actually plans health care in this province. It plans health care for hospitals, for long-term care, for community health centres and for all kinds of agencies. To say that we can't delve into that and make recommendations to me seems like, then why bother doing this review? Because those are the agencies that get impacted, and at the end of the day the patients who actually seek care from those agencies are the ones who are ultimately impacted. I think that to draw a line in the sand is not doing Ontarians any justice.

The Chair (Mr. Ernie Hardeman): No, and I would just point out that we're not intending to draw a line in the sand; we're just saying that if we have to go beyond what the motion from the Legislature says, we have a right as a committee to decide to do a full review of the CCACs, but it wouldn't be part of what they asked us to do, so it would be a separate entity.

M^me^ France Gélinas: Okay. I don't like word-smithing, but I want to be clear, and that will be to the Clerk. For the Clerk, is the mandate of the committee written in such a way that if our recommendations fell outside of this particular bill, then we could not make such a recommendation?

The Clerk of the Committee (Ms. Valerie Quioc Lim): Because the House is specific in that we're looking at the Local Health System Integration Act—and in the motion, it does say, "including its recommendations with respect to amendments to the act and the regulations", so we do have to caution that the committee stay within that mandate. It is a statutory requirement, review of that legislation.

M^me^ France Gélinas: But there's also a sentence in the motion that we got from the House that says that other work as—I forgot the—

The Clerk of the Committee (Ms. Valerie Quioc Lim): "Shall consider, but not be limited to." The motion has set out that the committee is to look at the legislation, and under that, to consider different things, but we have to really stay within the legislation.

M^me^ France Gélinas: Because we've been requesting documents right now from CCACs that have nothing to do with the LHINs. They have to do with elements of what we've heard that we wanted to check for ourselves, so we've been requesting documents. Are we inside or outside of our mandate when we do that work with CCACs?

The Chair (Mr. Ernie Hardeman): We're right on the line.

M^me^ France Gélinas: Okay.

The Chair (Mr. Ernie Hardeman): I say that in a serious way. We're right on the line, because if we pass a motion like this, we're on the other side of the line, we are now doing a complete review of the CCACs. But what we've actually done so far with the CCACs is not how they operate; it's strictly on the pay scale for certain people. We haven't done anything at this point on looking to see whether, in fact, they're putting enough into the front line, how much and things like that. That would be a different report. Again, this committee has the power and the ability to set its own agenda as to what it does want to review, but that would not be part of what they've asked us to review from the House.

M^me^ France Gélinas: So, back to the Clerk, I would like you to check, because some of the recommendations that may come forward may have nothing to do with the act—they have to do with the findings that we have—are we wasting our time here as to everything else that we've heard about that won't necessitate a change to LHSIA, but per se is out of our responsibility? Is this what you're saying?

The Clerk of the Committee (Ms. Valerie Quioc Lim): I will check on that, because I know you were talking about things that we've heard and observed from presenters. I believe that we do have to stay within the legislation, but I will get back to you about how far, because of what we've heard from presenters and the information that we've checked because of what the committee has heard.

M^me^ France Gélinas: Okay. We may make changes to the law, but we may also—or propose changes to regulations or propose changes to the way they do things that will have nothing with the way the law is written. It will have to do with the way it is interpreted, the way it should be carried out, the impact that it has had on the health care system. That was my understanding of what we were doing, and now you're kind of narrowing it to the point where I'm wondering what we're doing.

Ms. Helena Jaczek: I think everything that we've requested so far falls under the mandate that we've been given, because the LHIN is officially, through legislation, the transfer payment mechanism to the CCACs. We have been asking about how those dollars transferred by the LHIN to the CCAC are accounted for. As far as I'm concerned, everything we've done is in the spirit of what the powers of the LHIN are and how they are exercising those powers.

M^me^ France Gélinas: I feel the same way.

Ms. Cindy Forster: Yes, I do too.

The Chair (Mr. Ernie Hardeman): I would just clarify again: Our mandate is that all the legislation and regulations made under it is what we're reviewing. So as long as the regulations that you refer to are not regulatory changes that need to be changed because of the CCAC act, as opposed to the LHIN act—then we would be over the edge, and that's why a full report would be inappropriate to be able to implement. But I think the committee has all the power to make recommendations on the information we were able to gather on the transfer—that the transfer, that which is being transferred to the CCAC, is questionable if you look at that, compared to what's being transferred to someone else. We can't maybe go all the way in to find out where they're spending it, but we can find out which organizations are getting the money, because that's part of the LHIN mandate.

M^me^ France Gélinas: Then I would ask the Clerk to check, if we make recommendations that go outside of this law, are we outside of our mandate? It's quite obvious that we've heard a lot of things that did not have to do with the act; it had to do with the carrying out of the function that came from that act, including following the dollars.

The Chair (Mr. Ernie Hardeman): Lastly, what we heard is not in question. The mandate is not for what people are telling us. The mandate is what we report back to the House. So as long as we don't come forward with—and that's why I say you can decide at that point whether you want to do a total review of the CCAC and put that in a report, because if it's CCAC matters, you would not be able to put it as part of the LHIN review.

M^me^ France Gélinas: That's what the Clerk will check. Thank you.

The Chair (Mr. Ernie Hardeman): Anything further on that? If not, we're ready to move in camera.

The committee continued in closed session at 1433.

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ISSN 1710-9477

Legislative Assembly
of Ontario

Second Session, 40th Parliament

Assemblée législative
de l'Ontario

Deuxième session, 40e législature

Official Report of Debates (Hansard)

Tuesday 15 April 2014

Journal des débats (Hansard)

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Standing Committee on Social Policy

Ryan's Law (Ensuring Asthma Friendly Schools), 2014

Comité permanent de la politique sociale

Loi Ryan de 2014 pour assurer la création d'écoles attentives à l'asthme

Chair: Ernie Hardeman
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Room 500, West Wing, Legislative Building
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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 15 April 2014

Mardi 15 avril 2014

The committee met at 1606 in committee room 1.

RYAN'S LAW (ENSURING ASTHMA FRIENDLY SCHOOLS), 2014

LOI RYAN DE 2014 POUR ASSURER LA CRÉATION D'ÉCOLES ATTENTIVES À L'ASTHME

Consideration of the following bill:

Bill 135, An Act to protect pupils with asthma / Projet de loi 135, Loi protégeant les élèves asthmatiques.

The Chair (Mr. Ernie Hardeman): I call the April 15 meeting of the Standing Committee on Social Policy to order. We're here today to do clause-by-clause on Bill 135, An Act to protect pupils with asthma.

Before we start dealing with the amendments to the bill, are there any general comments or questions that the committee members would like to make to the bill? Yes, Ms. Forster?

Ms. Cindy Forster: Thank you, Chair. I want to actually thank the member for bringing forth this important bill that will protect children in the school system and in our communities. I'm happy to be here today to actually participate in clause-by-clause. I wasn't here for the presentations, but certainly I have some experience in my background of dealing with patients with asthma. I've taken the opportunity to read a lot of the presentations.

The bill deals directly with children in the school system and their asthma medications, primarily asthma inhalers. But when I read some of the background information, clearly the bill doesn't go far enough to deal with other kinds of illnesses and conditions that children can have in our schools. There are children with diabetes, children with epilepsy, children with cardiac conditions, all of which may or may not be on a particular medication. I think it's important that we acknowledge that this isn't going to be the fix for every child in the school system here in the province of Ontario.

With those comments, maybe the member—

The Chair (Mr. Ernie Hardeman): Thank you very much for that. I do want to suggest that we did hear a number of presenters dealing with those types of issues as we were hearing from the public on the bill. We thank you for reiterating those.

Are there any other—

Mr. Michael Mantha: Chair? Chair, can I have a few—

The Chair (Mr. Ernie Hardeman): —general comments to the bill? To the bill—

Mr. Michael Mantha: Yes, absolutely.

The Chair (Mr. Ernie Hardeman): Not to the merits of the bill. The merits of the bill were discussed in the public hearings.

Mr. Michael Mantha: No, absolutely. What I did want to talk about is, I did participate in the hearings where we had a lot of stakeholders who came in and voiced their views in regard to how this could potentially impact individuals, and I really enjoyed hearing the different views from all who were involved, particularly from my colleagues in the Conservative Party as well in regard to the importance of it.

I've gone through all of the amendments, and from what I gather, looking at the amendments, some of these are going to require some very serious discussions in regard to how we can proceed to benefit the children, who should be our goal, at the end of the day, in regard to how we can assure that they're going to be able to have their puffers with them and that the responsibility lies in a particular area, whether it be with the principals, with the school boards or with the parents involved. So there are some amendments that are going to require some lengthy discussions.

I hope that we can move this forward. But again, it's going to require some explanation by some of the individuals around the table as to where they came from with their amendments, and I look forward to having those discussions.

At the end of the day, we really do want to take the appropriate steps to make sure that our children are cared for, that they have the ability to make sure that they're in a safe environment and where those responsibilities are going to lie—that we make sure that those kids are going to be safe. Whether they're in a school environment or at a school activity, we need to make sure that the proper steps and the policies are in place to care for them so that moms and dads who are sitting at home don't have to worry about it and that the doctors can provide the appropriate medicines for those kids so that they can apply the medicines when they need them.

I'm looking forward to engaging in a fruitful discussion around the table, because when we left here last week, in my mind, I had a clear vision as to where we were going. Again, I'm going to enjoy having the discussions in regard to where certain individuals or

certain parties took a particular position in introducing their motions, and rightfully so. I look forward to having that discussion.

The Chair (Mr. Ernie Hardeman): Anything further on the general thrust of the bill?

Mr. Bas Balkissoon: Just general.

The Chair (Mr. Ernie Hardeman): Just general on the bill. Mr. Balkissoon.

Mr. Bas Balkissoon: I just want to thank my colleague across the way for bringing the bill. As it was debated in second reading, most of us are supportive of his intent and what he's trying to accomplish, and we continue to support the bill.

Just to comment on my colleague from Niagara—not Niagara—

Mr. Mike Colle: Welland.

Mr. Bas Balkissoon: Welland. There are other situations for students in school that require looking at. I think it was mentioned by one of the deputants last week that they're working with the ministry to report back on how to do it. I think the amendments that are submitted from my colleague from Algoma–Manitoulin are mostly technical in nature as to how the bill will apply on the ground, in the school, and the principals and the parents and the students will collaborate to make this work.

Hopefully, we can discuss the amendments that the government has supported, but they're strictly how to deliver it, and they're technical in nature.

The Chair (Mr. Ernie Hardeman): Any further comments?

If not, we'll go through the bill section by section. As we get to each section, if there are no amendments, then we will vote on the section as it's written. If there are amendments, we will then go through it with the proposed amendments and have them read into the record.

Shall section 1 of the act carry? Carried.

Are there amendments to section 2?

Mr. Bas Balkissoon: Yes, we have a government motion.

The Chair (Mr. Ernie Hardeman): The first one is a government motion. Mr. Balkissoon.

Mr. Bas Balkissoon: I move that paragraphs 1 to 6 of subsection 2(2) of the bill be struck out and the following substituted:

"1. Strategies that reduce the risk of exposure to asthma triggers in classrooms and common school areas.

"2. A communication plan for the dissemination of information on asthma to parents, pupils and employees.

"3. Regular training on recognizing asthma symptoms and managing asthma exacerbations for all employees and others who are in direct contact with pupils on a regular basis.

"4. A requirement that every school principal develop an individual plan for each pupil who has asthma. In developing an individual plan, the principal shall take into consideration any recommendations made by the pupil's physician or nurse.

"5. A requirement that every school principal inform employees and others who are in direct contact on a regular basis with a pupil who has asthma about the contents of the pupil's individual plan.

"6. A requirement that every school principal ensure that, upon registration, parents, guardians and pupils shall be asked to supply information about asthma."

The Chair (Mr. Ernie Hardeman): You've heard the motion. Clarification and explanation for the motion?

Mr. Bas Balkissoon: If I could provide the explanation to help my colleagues.

Section 2(2)1: We've removed "field trips" as it would be challenging for school boards to control environmental factors outside of the school setting: as an example, pollen, animals, scent etc.

Section 2(2)3: The original language, in our opinion, is a little too vague. The motion adds the word "symptoms" and "exacerbations" to clarify areas that school boards would be required to address through school board training.

Section 2(2)4 clarifies that a pupil's physician or nurse will not direct the development of the plan since neither would have insight into the school setting; for example, the layout and the environment around a school, because each school setting is different.

The "under the direction" language also means that the creation of a student's individual plan would be contingent on a physician. It also raises the risk of additional fees for parents as this work is not covered by OHIP. Removing "under the direction" and substituting "shall take into consideration" allows for a principal to start developing a plan but still maintains the required involvement of the pupil's physician or nurse in developing a plan where applicable. It also alleviates the concern that a physician or nurse may have charged for this service.

Section 2(2)5: Moving 2(2)5 to a new stand-alone section 2.1 will create a stronger legal right for a student opposed to the weaker policy instruction currently in the bill. This strengthens a student's right to carry their asthma medication. This is contingent on passing a couple of motions that will come later.

Lastly, it creates a new requirement for the principal to inform all relevant staff and others of an individual's plan.

Section 2(2)6 removes redundant portions since it will be addressed through a new section 2.1.

Those are the technical explanations for the changes the government is recommending, and it's mostly to accommodate all the stakeholders who are involved.

The Chair (Mr. Ernie Hardeman): Further discussion? Mr. Yurek.

Mr. Jeff Yurek: Thank you, Chair. Thank you very much for the amendment. Just a question on point number 4, "the principal shall take into consideration any recommendations." I know, working with the principals' council, that they're concerned with having the actual action plan from the doctor. They want that included. They don't want the principals to be responsible as to how the student and when the student is to take the medication.

I would recommend changing "the principal shall take into consideration" to "the principal shall include an

asthma action plan from the pupil's physician or nurse or health care provider," whoever's providing that service. Some doctors might charge an extra fee, but when you're diagnosed with asthma and you go to a specialist of such, you are given an asthma action plan. All we're really asking for, and the principals also, is a copy of that plan so they know how the student is to take their reliever medication.

Mr. Bas Balkissoon: Mr. Chair, if I could explain. I think the explanation that we would give is that, yes, if the doctor provides it to the principal, we'll accept, but in a case where a student may not be able to get that doctor's report in time, the principal will proceed still and that could come at a later time. It's to provide flexibility because access to doctors is not available in all regions as it is in some of the urban centres. So it was to provide a little bit of wiggle room to allow the principal to create that plan and work on it. I know what the principals' intent was, but we still see it as being workable.

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The Chair (Mr. Ernie Hardeman): Mr. Yurek.

Mr. Jeff Yurek: I understand that there's a lack of physicians in this province, especially in rural Ontario. However, you've added nurses, and I do like the third party's suggestion of a primary health care professional who has the ability to write an asthma action plan. Technically it doesn't matter who is writing it, provided they have the authority to do so. What we want and what the schools want is an actual asthma action plan planned out by a medical professional. The teachers and the principals aren't medical professionals. They don't study medication, they don't study diagnosis, they don't study disease, and we should not expect them to do so. We want to make this as easy for the teachers and principals as possible and maintain the student's safety. Obtaining an asthma action plan from a medical professional—we can outline which ones—will do so. I think adding this in, any recommendations—you're going to get negative feedback from the system and, in fact, probably some parents who actually want the principal and the school system to take into full consideration what the doctor or health care provider wants to put into place.

Mr. Bas Balkissoon: Chair, if I could just answer his concern?

The Chair (Mr. Ernie Hardeman): You go ahead and answer the concern, and then we'll go to the third party.

Mr. Bas Balkissoon: Okay. I did read the NDP motion on designating a health care provider. I thought that maybe it would be the solution. But upon research, a health care provider is a long list of people and we had some concerns about that, so we're being specific to the physician or the nurse.

I'll give some examples. If you say "health care provider," you're looking at both the physician and the doctor. It could also be a pharmacy, it could be a laboratory, it could be an ambulance service, it could be a paramedic, it could be someone working in a home for special care—

Mr. Jeff Yurek: They would still have to operate under their scope of practice. If a paramedic writes an asthma action plan and signs off on it, he's out of his scope of practice. We just—

Mr. Bas Balkissoon: I think the ministry had some concerns about that.

The Chair (Mr. Ernie Hardeman): I think we have the position rather clear as to the concern and the request difference.

The third party, Ms. Forster.

Ms. Cindy Forster: Yes. I actually have a number of issues that I want to speak to here.

The first amendment, subsection 2(2), "1. Strategies that reduce the risk of exposure to asthma triggers in classrooms and common school areas": In the original bill, it included field trips. The government's amendment is actually excluding field trips, which are a big part of the curriculum in schools.

In addition to that, there's the issue of busing. Many children in this province get to school and home on buses. Many of them have bus trips for as long as an hour each way to actually get to their schools, but I don't see any kind of inclusion with respect to that. At the moment I'm not clear on whether busing is a school board issue or whether it is a Ministry of Education issue, but I think it's something that also needs to be highlighted and taken into account.

There's no point in keeping the child safe with a plan at school if they're not going to be safe from the moment they leave their door on a bus or if they're not going to be safe when they're out on a field trip. Children participate in many field trips throughout the school year. I think to remove that is a detriment to the children that we're actually trying to protect.

On the issue of the communication plan, there was no change there.

"3. Regular training on recognizing and managing asthma...." The amendment is "Regular training on recognizing asthma symptoms and managing asthma exacerbations for all employees and others who are in direct contact with pupils on a regular basis." I don't know whether you're referring to other employees in the school system. Once again I go back to the fact that there may be other people when you're out on school trips, and then you also have the issue of the transportation of children. In fact, if that's a Ministry of Education responsibility, are bus drivers going to be trained, as well, to assist children with their asthma puffers?

The Chair (Mr. Ernie Hardeman): Ms. Forster, on number 2, it seems to me the two are identical.

Ms. Cindy Forster: That's what I said. I said there was no change.

The Chair (Mr. Ernie Hardeman): So if we keep the debate on this—there may be other ones that do want to change that. But we're dealing with the amendment, so if we speak to those that are changing the original bill—

Ms. Cindy Forster: And I am, Mr. Chair, actually. I just said for number 2 there was no change.

The Chair (Mr. Ernie Hardeman): Yes.

Ms. Cindy Forster: With respect to removing the requirement for principals to actually take direction from physicians as opposed to just considering those recommendations, I think that is also to the detriment of the students who have asthma. Clearly, it is the physician or the health care provider who has the expertise to direct an action plan with respect to a child's asthma. How would a principal or a school system even put into place a plan without initially having that direction?

I agree that there may be some costs involved in that process and there may be something that's needed to be done there, but I know that on the issue of "health care provider", for example—I know the government has raised the issue of a long list of health care providers, but I think in this particular instance, you'd be looking at a physician, a nurse practitioner or a registered nurse.

In 2010, there were a million people in this province without physicians, so chances are every child who has asthma isn't necessarily going to have immediate access. There are not community health centres or family health teams in every community, and so I think it's important for the government to turn its mind to the issue of health care provider versus the issue of just a physician.

The last piece with respect to number 5: It deletes the current paragraph 5, which states that schools must permit a pupil to carry asthma medication if approved by the parent/guardian and physician, and it inserts a new paragraph that creates an onus on principals to inform employees of the contents of individual plans for pupils with whom the employees are in regular contact. Currently, the only requirement is that an individual plan includes directions to employees for monitoring and avoidance strategies.

So the paragraph requiring every school to permit a pupil to carry their asthma medication if they have the necessary permissions and approvals to do so—although it's not dropped entirely from the bill, it's moved to section 2.1, and it's moved out of that actual policy. I'm questioning why that was moved. I don't know if anyone has the answer to that or if legislative counsel could address what the impact of not having that particular statement in the policy has on the students and what impact it has to the bill.

Mr. Bradley Warden: I think that, perhaps, the members moving the motion might be able to speak better to the impact than I could.

Mr. Bas Balkissoon: It's up to the Chair.

The Chair (Mr. Ernie Hardeman): Yes.

Mr. Bas Balkissoon: If I could go back again to your concern that the doctor should direct and the nurse should direct or whoever should direct, the issue was that it's a plan that the board will have at the school. The principal will have the plan and the principal will have to execute that plan, or the employee that the principal so designates. So really, this is what we were looking at: Who is responsible for creating the plan and executing the plan? Consulting with a physician would give you the input on how to create that plan to suit that individual student. That would be our position as to why we're recommending this particular change.

The last question you asked: If you don't mind repeating it, I'd really appreciate it.

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Ms. Cindy Forster: It was the section about whether the pupil can actually carry their asthma medication, if approved by the parent, guardian and physician. It actually takes it out of this section and moves it to 2.1 by itself. I'm wondering what the rationale for that was. It's in a new stand-alone section.

Mr. Bas Balkissoon: Just one second. Let me see if I can find it.

The Chair (Mr. Ernie Hardeman): The motion that we're presently dealing with?

Mr. Bas Balkissoon: Yes, I think it's in a motion later on.

Ms. Cindy Forster: It is, but it's being deleted from the current bill under section 1, so it's directly related to section 1.

The Chair (Mr. Ernie Hardeman): But we're in this—

Mr. Michael Mantha: It's under 2(2)5. Subsection (5), Mr. Chair.

Interjection.

Mr. Bas Balkissoon: That's what I'm trying to find.

Ms. Cindy Forster: Under the current bill, section 2(2)5: "A requirement that every school permit a pupil to carry his or her asthma medication if the pupil has his or her parent's or guardian's permission and his or her physician's approval to do so."

So currently, it's under "Contents of asthma policy," but it's being removed in your amendment.

Mr. Bas Balkissoon: I did speak to that, and I'll just repeat it. What we're seeing here is if we move it as a stand-alone clause, it actually strengthens the legal right for a student, as opposed to the weaker policy instruction that's currently in the bill. So where it's in the bill as part of that larger clause, we see that if it stands on itself, it gives the student more legal right to—

The Chair (Mr. Ernie Hardeman): Could I ask for a legal opinion as to whether that's the case?

Mr. Bradley Warden: Well, I think generally, paragraph 5 is now contained in subsection 2(2), where it's about a board's policy. It would be moving it to a new section 2.1, so it would become a stand-alone provision that isn't part of a board policy, and this is why the member's referring to sort of moving that right out of the board policy in 2(2) and into its own section.

The Chair (Mr. Ernie Hardeman): I would point out, in process, there's a bit of a challenge here. The committee has to be confident that if you pass this motion, that next motion to put it back actually passes, okay? Because, in process, how it's written here, it wouldn't automatically put it in that section.

Mr. Bas Balkissoon: That's why I said, Chair, that it's contingent upon us adopting 3A and 4, to make it stronger.

Ms. Cindy Forster: So what you're trying to do is actually give the right to the pupil—

The Chair (Mr. Ernie Hardeman): If everyone's convinced of that, you'd have every ability to do that.

Ms. Cindy Forster: You're trying to give the right to the pupil and actually remove it from board policy, so that the board would no longer have the right to direct whether or not a child could carry it.

Mr. Bas Balkissoon: That's what we're trying to do.

Ms. Cindy Forster: It would be up to the pupil, with their parent's or guardian's permission. Okay.

Interjections.

The Chair (Mr. Ernie Hardeman): If counsel—I'm going back a long ways. If the committee wishes to deal with that section first, before we finish here, we can leave this motion, with unanimous consent, and we can put number 5 where you want it and vote on it there.

Mr. Bas Balkissoon: I'm in your hands, Chair.

Ms. Cindy Forster: No. No, we want to finish with what's in front of us, Chair.

Interjection.

The Chair (Mr. Ernie Hardeman): Okay. It has to be unanimous consent, so we don't have it. Carry on.

Mr. Michael Mantha: I wanted to raise just a couple of questions in regard to particularly under subsection 2(2)1, which is the field trips. Why do we want to remove that from the policy? It just—

Mr. Bas Balkissoon: As I said in my explanation when I started out, it was removed because we felt that it would be very challenging to school boards, school principals and schools to control the environment wherever a school trip takes place, and to write a plan that reflects that environment. This is why we restricted the plan to the school itself and the common areas around the school property.

Mr. Michael Mantha: But, again, don't you think the school—my concern is the environment that you get out of the school is not just within the walls of the school or the schoolyard. You get it from being exposed out in nature. You get it from going to skating rinks. You get it from all different types of environments. To not have a plan, or not have a course of action of how certain individuals who are in the roles of responsibility are going to be expected to act or to conduct, or even the children who are going to be exposed to these environments—if you don't includes those, aren't we putting them at risk?

Mr. Bas Balkissoon: Maybe my colleague who is a medical expert can comment.

The Chair (Mr. Ernie Hardeman): Ms. Jaczek.

Ms. Helena Jaczek: I think, Mr. Mantha, if you read the whole wording in section 1, in this case, it's "Strategies that reduce the risk of exposure to asthma triggers in classrooms and common school areas." That's the piece where the school would have difficulty in controlling the risk of exposure on field trips.

I think you need to put it all together. It does not, in any way, reduce the responsibility of the school to safeguard the child's health, but it relates directly to reducing the risk of exposure. I think that was the intent: How can the school reduce the risk of exposure to environmental factors outside their own building, as in a field trip? But it does nothing to say that the child shouldn't have their puffer, that people shouldn't be educated—all the staff that accompany the child on the field trip. It doesn't, in any way, lessen their responsibility for the safety. That's the way I'm interpreting that.

Mr. Michael Mantha: Then in the original—again, pardon my ignorance—what was the purpose of having "field trips" there at the beginning of the bill?

Mr. Bas Balkissoon: He moved the bill, not me.

Mr. Michael Mantha: No, I want to know, because maybe there's an explanation to that. I would really appreciate it, because, from what I understand, a child's education is not just within the walls of the school.

Mr. Bas Balkissoon: And we're just trying to make it workable, from the ministry's standpoint.

Mr. Michael Mantha: I guess my concern is, I look at it from a perspective that, again, the education of the kid is not just within the walls, because there are activities, there are museums, where they're going to be going out to. There are quite a few other ventures—

Mr. Bas Balkissoon: But, as my colleague says, I don't think the responsibility changes. It's how you control the risk factors.

Mr. Michael Mantha: Okay. Is it possible, Chair, to ask Mr. Yurek to provide me with some type of clarification as to why "field trips" was there?

The Chair (Mr. Ernie Hardeman): That's why he's here.

Mr. Jeff Yurek: Thanks very much, Chair. So, basically, the thoughts with the field trips is not necessarily for the school system to go to, say, a museum and clean up all the pathogens or allergens or what have you. The idea is to ensure that there's a plan in action for the teacher taking the student to the field trip to ensure that there's a limited exposure to an allergen. So if the teacher does know they're going on a school trip to a drug-manufacturing facility, they know ahead of time that when they come up to where the powders are mixed into the capsules, that student should probably have precautions—a mask, or perhaps move around—so that they can prepare with that facility, saying, "I have a student who might have a problem with asthma. Do you have stuff prepared?" That's the intent.

Now, whether or not the lawyers from the ministry have taken a look at this and have decided that it will be looked at as another way that may forever prevent field trips from going on, then I have a concern if that's the way they're going to interpret this. The intent was just to ensure that there's a plan of action and there's a safety factor for the students going on field trips, not necessarily to cancel field trips or for, in fact, the school system to start cleaning up where they're going.

Ms. Helena Jaczek: Chair, the wording is, in the original bill, "reduce the risk of exposure" as opposed to ensuring an action plan is in place during field trips. I think that's why we're reacting to that.

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Mr. Jeff Yurek: Sure. I understand both sides here.

The Chair (Mr. Ernie Hardeman): My kind of man.

Ms. Forster?

Ms. Cindy Forster: Thank you, Chair. I actually didn't get an answer to my question with respect to transportation of students from home to schools. Does that actually fall under the school boards' authority or does it fall under the Ministry of Education's responsibility? How are we going to implement an action plan that protects—

Mr. Bas Balkissoon: Currently, transportation is the responsibility of the school boards.

Ms. Cindy Forster: Of the school boards.

Mr. Bas Balkissoon: Yes.

Ms. Cindy Forster: So are people that are responsible for busing going to be trained and educated with respect to—

Mr. Bas Balkissoon: If there's a plan written for the student, it would apply, because the school board takes responsibility.

Ms. Cindy Forster: Okay.

The Chair (Mr. Ernie Hardeman): It's in the bill?

Mr. Jeff Yurek: Chair, just to answer, that is taken care of in the bill. I mean, it talks about—that employees will be part of the communication plan. A bus driver, if it's out of the school board, will be an employee of the school board.

Ms. Cindy Forster: Bus drivers are considered employees of the school?

Mr. Bas Balkissoon: They're under the direction of the school board on contract, so they would have to get the same training for the first part of the bill.

Ms. Cindy Forster: I would say that bus drivers are probably employees of Laidlaw or the bus companies on contract and probably have no responsibility other than transporting the kids back and forth.

Mr. Bas Balkissoon: I wouldn't assume that, Chair, unless you actually read the bus contract.

Mr. Mike Colle: They have to abide by school board policy.

Mr. Bas Balkissoon: They would have to follow school board policy. I would think all contracts are written that they would have to abide with school board policy.

Ms. Cindy Forster: I'll hold you to that.

Mr. Bas Balkissoon: I'm not a lawyer, but I would assume the contract would have to cover that.

The Chair (Mr. Ernie Hardeman): Does the lawyer have an opinion on that? No? I have one, but I don't want to start a fight.

Mr. Michael Mantha: Maybe counsel can help you with this one. Subsection 2(2), paragraph 1, with the amendment that was proposed, says, "Strategies that reduce the risk of exposure to asthma triggers in classrooms and common school areas." If my concern is in regards to school trips or even on the bus, would it be so simple as to change "areas" to "activities"?

Mr. Bas Balkissoon: I would have to ask my staff in the ministry to review it.

Mr. Michael Mantha: I'm just wondering, because it would encompass—

Mr. Bas Balkissoon: Like I say, I would have to check. We would have to take a 20-minute break if you wished to move that in.

Mr. Mike Colle: Or you can make that inquiry of—

The Chair (Mr. Ernie Hardeman): You were asking a question?

Mr. Michael Mantha: Yes. That was my question. I'm asking—

The Chair (Mr. Ernie Hardeman): And what's the answer?

Mr. Bas Balkissoon: He's asking if we would add, instead of the word "areas"—I'm saying, anything different than our motion, I would need time to go back and—

Interjection.

Mr. Bas Balkissoon: That's legislative legal staff. I would want—

The Chair (Mr. Ernie Hardeman): The question, then, is removing the "s" from "areas"?

Mr. Michael Mantha: No.

Mr. Jeff Yurek: Changing "areas" to "activities."

Mr. Michael Mantha: Yes.

The Chair (Mr. Ernie Hardeman): "Areas" to "activities."

Mr. Michael Mantha: It reads right now, "Strategies that reduce the risk of exposure to asthma triggers in classrooms and common school areas." That's kind of tying us down to the school area. I'm just saying, if we were to change "areas" to "activities," does that not encompass if we were to go out, as to Mr. Yurek's point, on field trips, or while the child is travelling on the bus? Does that not include that? Does that open it up? Does that suit your need?

Mr. Bas Balkissoon: I would think if you leave it open to "areas," we would be looking at the field trips again and the environment that the child is being exposed to. We would have to outline all those risks and provide the training for all that risk and a whole lot more. The plan would have to cover that.

Mr. Michael Mantha: So "common school areas" would encompass—

Mr. Bas Balkissoon: It's everything in the school.

Mr. Michael Mantha: Everything in the school, but outside of the school realm, it doesn't.

Mr. Bas Balkissoon: Outside of the school realm, as my colleague, who is more medically trained than I am, has explained, there will still be protection for the child to make sure that the risk is reduced. Maybe she can repeat it again so you understand.

Mr. Mike Colle: Or we can get a clarification.

The Chair (Mr. Ernie Hardeman): For clarification, I think, again, we go back to Ms. Jaczek's comment about how one deals with reducing the risk—not with the child, but reducing the risk of it causing an attack. If you changed "areas" to "activity," you would be talking about what they're doing, not where they are, because you could be doing a school activity and nothing to do with the school at all, because it's that activity. And "area" is any area that's being used for the school purposes, other education purposes.

Interjections.

The Chair (Mr. Ernie Hardeman): In my opinion, a school area referred to here would be the school bus. It would cover it in there because that would be an area of school activity.

Mr. Michael Mantha: We heard from the principals' council that was here—or at least I got some clarification from them—that number 4 raises a concern with that particular group, where we remove the requirement that a principal create an individual plan under direction and we're replacing it with "shall take into consideration."

Are we not putting the onus or more of a responsibility now on the principals, which they didn't want to have in the first place? It was a very big concern that they had. They wanted to have a plan where, through a discussion with—well, actually, an action plan. They wanted to have something where it wouldn't have been them making that decision; that it's based on sound medical information and that it's also coming directly from the doctor and also from the parents.

By changing this and putting in "shall take into consideration"—throughout my area, particularly in Algoma–Manitoulin, I can tell you, we have a shortage of doctors. If you have some you can send my way, thank you; I'll take them wholeheartedly and I'll travel them back and forth if you want me to. But it is a challenge for us and there is a very big fee that's attached to this. If I'm going to be consulting with my doctor—and trust me, even myself, I have a great doctor, but it takes me at times anywhere between a month and a month and a half to get to see him, and I have a family doctor, whereas others don't. It's going to be very difficult for them to actually get the direction from a doctor.

There's an onus that's going to be put on the principals here and I think, from what I understood when we were here during discussions last week, there's a huge concern from them, where the responsibility will lie on them to take it into consideration, and taking it into consideration might be: The child has his puffer. He comes in and he has a discussion with the parents. How is that plan going to be implemented?

Mr. Bas Balkissoon: Okay. If I were to read you what's in the bill, it says: "A requirement that every school principal develop an individual plan for each pupil who has asthma. The plan must be developed under the direction of the pupil's physician." The principals were very concerned about that wording.

The wording that we have now moved in our motion—we have consulted with the principals' council and they are much more supportive of this than what's in the original bill. We also leave the flexibility there that you can develop a plan without getting the direction from the physician if the physician is not readily available, and it will be an interim plan until you get the instructions from them. That way, you're not denying the student the opportunities to participate if the principal believes that the risk factor is low. But if you look at the original wording, that held the principals responsible at a much higher level.

The Chair (Mr. Ernie Hardeman): Mr. Yurek?

Mr. Jeff Yurek: Thank you, Chair. I'm just wondering if you'd be open to changing the wording to: "In developing the individual plan, the principal shall include an asthma action plan made by the pupil's physician or nurse"?

Mr. Bas Balkissoon: "Shall include"—run that by me again.

Mr. Jeff Yurek: "Shall include an asthma action plan made by the pupil's physician or nurse." I believe that will take care of the principals' concern. They're not making a medical decision. They are still creating the plan, except the medical direction is coming from a health care professional.

It also takes into consideration what the principals raised with me and the fact that sometimes parents think their child shouldn't be participating in a sport, yet the doctor is saying, "No, their asthma is not that bad and they should be exercising." Including the asthma action plan would, I think, incorporate what the NDP is looking for, and the government at the same time. I would be open to changing that.

Mr. Bas Balkissoon: Chair, if we could take a short five-minute break, I'll consult with my staff and I'll give you an answer.

The Chair (Mr. Ernie Hardeman): We can do that, but if you are requesting to amend the motion, you have to have an amendment put forward. We can't change it across the aisle. We have to do it officially.

Mr. Bas Balkissoon: I'd be happy to make it a friendly if you give me five minutes.

The Chair (Mr. Ernie Hardeman): You're entitled to ask for a recess.

Mr. Michael Mantha: Chair?

The Chair (Mr. Ernie Hardeman): Yes?

Mr. Michael Mantha: To finish off on my point in regard to the principals, just for discussion purposes, and then I think we'd agree, I wanted to, for the record, read out what the OPC had indicated in their words that they shared with us last week. Can I do that now, or would we have to wait till after we come back?

The Chair (Mr. Ernie Hardeman): You can read it now.

Mr. Michael Mantha: They clearly stated, "The ultimate decision in terms of the diagnosis and the treatment plan lies with the medical professional, and that's the piece that we strongly, strongly support being in place. The principal can hold or can manage the treatment plan, but we can't develop it."

I think they were very clear that that direction needs to come from the medical professional or the health care provider. I think what this is telling us is that there is an onus that's falling on the principal.

Mr. Bas Balkissoon: You're talking about a treatment plan—

The Chair (Mr. Ernie Hardeman): Okay. We're going back now. We're going back to the original here, and you wanted a break to get the information.

The committee recessed from 1652 to 1713.

The Chair (Mr. Ernie Hardeman): I call the committee back to order. We have the printed amendment. Mr. Yurek.

Mr. Jeff Yurek: I move an amendment. I move that motion 1.1, which amends paragraphs 1 to 6 of subsection 2(2) of the bill, be amended by striking out paragraph 4 and substituting:

"4. A requirement that every school principal develop an individual plan for each pupil who has asthma. In developing the individual plan, the principal shall include an asthma action plan made by the pupil's physician or nurse, if any, and any recommendations made by the pupil's physician or nurse."

The Chair (Mr. Ernie Hardeman): You've heard the motion. Debate? Ms. Forster.

Ms. Cindy Forster: How many amendments can there be to the amendment?

The Chair (Mr. Ernie Hardeman): There's only one amendment per amendment.

Ms. Cindy Forster: Only one amendment per amendment.

The Chair (Mr. Ernie Hardeman): You can read that once this one is done—

Ms. Cindy Forster: Right.

The Chair (Mr. Ernie Hardeman): —unless it deals with exactly the same item.

Ms. Cindy Forster: Okay. Well, it does deal exactly with the same item.

The Chair (Mr. Ernie Hardeman): No, the same list or the same number 4.

Ms. Cindy Forster: The same number 4.

The Chair (Mr. Ernie Hardeman): So the motion is on the floor. Debate on this motion, this amendment?

Ms. Cindy Forster: I can actually speak to the issue that I spoke to a little bit earlier, about the pupil's physician or nurse. It's certainly problematic for us, and we will bring forward another amendment to that, but I'll speak directly to that piece.

I know that during the public hearings, we had a presentation and a letter from the RNAO, from Doris Grinspun, and I quote: "In addition to making Ryan's Law more comprehensive by extending it to any life-threatening health condition, the RNAO"—which represents more than 100,000 nurses in this province—"recommends that the language of the bill be revised to reflect current realities of interprofessional practice. As it stands, Bill 35 contains physician-centred language that does not reflect the primary care being provided each day by nurse practitioners and RNs in community health centres, NP-led clinics, family health teams and nursing stations"—in northern parts of our province. "Aspects of the bill such as individual plans being 'developed under the direction of the pupil's physician' does not reflect the interprofessional collaboration of regulated health professionals in primary and specialized settings who are responsible for helping clients manage increasingly complex acute and chronic health conditions. Thus, we recommend replacing this language by current language used in primary care which refers to 'primary care provider.'

"The strength of RNAO is nurtured by the knowledge, expertise and unwavering commitment of our members for better health outcomes for all Ontarians, especially children. Our members include experts in school health, public health, community health, pediatrics, primary care and a range of specialized nursing areas. Two relevant resources available online are RNAO's Best Practice Guideline on Promoting Asthma Control in Children, and the Community Health Nurses' Initiatives Group recent paper, Healthy Schools, Healthy Children: Maximizing the Contributions of Public Health Nursing in School Settings.

"We hope you will consider these recommendations."

You have the experts actually telling you that the proper terminology is "health care provider." You're not going to be getting asthma instruction from a social worker in a family health team or in a community health centre.

Those are my comments with respect to this amendment.

The Chair (Mr. Ernie Hardeman): Okay. Further debate on the amendment? If not, all those in favour of the amendment?

Mr. Jeff Yurek: Chair, I just want to make one more comment. Sorry.

The Chair (Mr. Ernie Hardeman): All right, yes.

Mr. Jeff Yurek: I recognize the point the third party has made, and the amendment does include "nurse," so they will be included in making the asthma action plan.

Mr. Mike Colle: Yes, "nurse" is included.

The Chair (Mr. Ernie Hardeman): Yes, Ms. Forster?

Ms. Cindy Forster: Well, in fact, "nurse" doesn't appropriately define who could actually prescribe a treatment for a child, for a patient. A nurse could be a registered practical nurse who would not be able to do that. It doesn't speak specifically to "registered nurse" or to "nurse practitioner." To use just the term "nurse" is actually inaccurate.

The Chair (Mr. Ernie Hardeman): Okay. Ms. Jaczek?

Ms. Helena Jaczek: Yes, thank you, Chair. I want to acknowledge what Ms. Forster has said. I'm wondering if you would have a proposal to tighten the language. I guess, from our point, just saying "primary care provider" is not as specific as what you have in fact indicated. The appropriate health care professional who could produce an action plan for asthmatics, apart from physicians, would be nurse practitioners, registered nurses, nurses possibly in a community health team, and so on.

So I'm wondering would you perhaps propose some tight language but that would acknowledge that "nurse" is somewhat non-specific?

The Chair (Mr. Ernie Hardeman): We're not going to discuss what you might have to do. We have to deal with this motion as it is before us now.

With that, any further discussion on the amendment? If not, all those in favour? All opposed, if any? The motion is carried.

Further debate on the motion, as amended? Yes, Ms. Forster.

Ms. Cindy Forster: I actually wanted to speak to number 6 in this group of amendments from the government.

The current bill's number 6 speaks to, "A requirement that every school principal ensure that, upon registration, parents, guardians and pupils shall be asked to supply information about asthma, including whether a pupil has his or her parent's or guardian's permission and his or her physician's approval to carry asthma medication."

The government's amendment is proposing to reduce all the words after the word "asthma" in number 6, which would be the piece about whether the pupil has their guardian's, parent's or physician's approval to carry the asthma medication. I wanted to ask Mr. Yurek why he proposed that to start with, I'd like to ask the government why they're proposing to delete it, and I'd like to ask the government's ministry lawyer, if there's such a person here, and legislative counsel what impact that actually has on this bill.

The Chair (Mr. Ernie Hardeman): One at a time, here. Which one would you like first?

Ms. Cindy Forster: Mr. Yurek.

The Chair (Mr. Ernie Hardeman): Mr. Yurek.

Mr. Jeff Yurek: Thanks again, Chair. That was included to ensure that the principals and the teachers know both the doctor and the parents have given consent to carry the puffer or the reliever medication. If you look forward to section 2.1 of the bill, the motions further down the road, that is incorporated into that part of the policy. So it's taken care of further down the road.

Ms. Cindy Forster: I don't think it is.

Mr. Jeff Yurek: No, it says so right here.

Ms. Cindy Forster: Under which section?

Mr. Jeff Yurek: Government motion 4, v.3, section 2.1 of the bill.

The Chair (Mr. Ernie Hardeman): It's 3A of the package.

Ms. Cindy Forster: What's proposed, though, is different. It isn't immediately upon registration at a school for the pupil and it actually deletes "physician's permission."

Mr. Jeff Yurek: No, turn the page. We're not going to accept the first one. The second amendment includes the physician and the nurse.

Mr. Bas Balkissoon: Section 3A.

The Chair (Mr. Ernie Hardeman): You have the answer to that question?

Ms. Cindy Forster: Yes. It's under 2.1.

The Chair (Mr. Ernie Hardeman): Okay. Further discussion? Yes, Ms. Forster.

Ms. Cindy Forster: I have an amendment.

The Chair (Mr. Ernie Hardeman): Very good.

Interjections.

The Chair (Mr. Ernie Hardeman): If we could, very quickly—we have a slight delay again. The amendment would be in order, or is in order, save and except, as with the previous amendment, the number of the section that we're dealing with has been changed because it's being amended. So we need to reword it and legal counsel is presently—

Mr. Mike Colle: Yes, and she wants a change to it, too.

The Chair (Mr. Ernie Hardeman): Yes, but the section that she's changing is the same section that we were dealing with before. It's now numbered differently.

Interjection.

The Chair (Mr. Ernie Hardeman): We'll take a five-minute recess or whatever length of time after that that's needed.

The committee recessed from 1727 to 1756.

The Chair (Mr. Ernie Hardeman): We'll call the meeting back to order. As everyone can see, the time is fast clicking to adjournment.

Yes, Ms. Forster?

Ms. Cindy Forster: We're still having a bit of debate here about this. The information we got from the ministry would be that we could include physicians, pharmacists, respiratory therapists and nurse practitioners, but we're afraid that that may, in some instances, actually exclude a classification that would be qualified to do the action plan.

I'm thinking that we need to take a little bit more time. We still have a bunch of amendments before us, so maybe we can take a little bit more time to get the Definition right—because there really should be a definition.

The Chair (Mr. Ernie Hardeman): We really don't even need unanimous consent to take more time because we've just about run out of it today. There's not much to spare.

Mr. Yurek?

Mr. Jeff Yurek: Chair, I seek unanimous consent from the committee to place Ryan's Law, the clause-by-clause, at the first order of the next business meeting, and move all the extra business further down the line.

The Chair (Mr. Ernie Hardeman): You've heard the request for unanimous consent. Debate?

Ms. Forster.

Ms. Cindy Forster: I would suggest that we should have a subcommittee meeting, and we could do that as early as tomorrow, and then the subcommittee could determine where this can actually land, and maybe sooner rather than later.

The Chair (Mr. Ernie Hardeman): That would also require a motion from the committee, to have the subcommittee deal with that, because we're looking at changing the last subcommittee report that the committee has accepted. We can do that if you want to make that motion.

Ms. Cindy Forster: I would move that we have a subcommittee meeting scheduled to deal with the final disposition of this bill.

Mr. Jeff Yurek: Chair, can we get it on the record that the NDP went against my unanimous consent, that I asked for originally? I want to hear them say no.

The Chair (Mr. Ernie Hardeman): There's no recording of unanimous consent.

So with that, we have a suggestion that you want to have a subcommittee meeting. Would you move that motion?

Ms. Cindy Forster: I'll move a motion—

The Chair (Mr. Ernie Hardeman): Any objection to the motion to have a subcommittee report back to look at moving this bill forward?

Mr. Bas Balkissoon: I thought Mr. Yurek moved the first motion.

The Chair (Mr. Ernie Hardeman): Hmm?

Mr. Bas Balkissoon: Didn't Mr. Yurek also move a motion?

The Chair (Mr. Ernie Hardeman): He didn't get unanimous consent.

Mr. Bas Balkissoon: Oh. Okay.

The Chair (Mr. Ernie Hardeman): With that, we have a motion to do that. All in favour, say "aye." All opposed, say "nay."

The rest of us are going home. The meeting is adjourned.

The committee adjourned at 1759.

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SP-45 SP-45

ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40e législature

Official Report of Debates (Hansard)

Monday 28 April 2014

Journal des débats (Hansard)

Lundi 28 avril 2014

Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur l'intégration du système de santé local

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

Président : Ernie Hardeman
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Room 500, West Wing, Legislative Building
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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 28 April 2014

Lundi 28 avril 2014

The committee met at 1406 in committee room 1.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): We'll call the April 28 meeting of the social policy committee to order. We're here today to review the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of the act.

First of all, before we start, I have a statement here. Just for the record, we had considerable discussion about it at the last meeting, and the Clerk was asked to clarify what recommendations the committee can make under this review.

The order of the House clearly states that the Standing Committee on Social Policy be authorized to conduct a comprehensive review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act. The order also goes on to charge the committee with presenting a final report to the assembly, including its recommendations with respect to amendments to the act and its regulations.

Under the act, the LHINs have interactions with health services providers such as the CCACs, among others, by providing funds to and having service accountability agreements with them. I can allow some latitude in the committee's request for information in its observations and recommendations, as long as they relate to the LHINs' relationship and interaction with these providers. Please keep in mind that the committee cannot conduct a review of these providers under this order of the House.

So, just to clarify the position that was taken, then, and make sure—I sometimes, in debate back and forth, don't express it quite clearly, so we wanted the record to show the distance we can go. We can get information from the providers, but we cannot make that the focus of the report.

Yes, Ms. Forster?

Ms. Cindy Forster: Thanks, Ernie. So we could request contracts, for example, between the LHIN and the providers, but we couldn't go in and do a review of the management structure of a provider?

The Chair (Mr. Ernie Hardeman): Exactly.

Ms. Cindy Forster: Or we could request, really, any kind of financial information as it relates to the LHIN and the tendering of that—

The Chair (Mr. Ernie Hardeman): Yes. I think, in general terms, things that affect our LHIN review as it relates to the providers, which would be any information that would have been given or been agreed upon by the LHIN that goes with another association, would fit the review.

Ms. Cindy Forster: Right. Okay.

The Chair (Mr. Ernie Hardeman): I just want to say that this position wasn't in any way reflective that the CCACs have been in any way resistant to giving information. Anything that's freely given, the committee has a right to look at, but the committee report in the end will not be making recommendations of how that should be changed, because that wasn't the focus of this review.

Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Chair. To further clarify, what we're really saying is that we cannot make any recommendation about the structure of the CCAC, because that's under a separate act. That would require a separate study.

The Chair (Mr. Ernie Hardeman): Yes. I think there was some concern expressed at the last meeting—and that's why this statement—that we would also, because we would not be making that in our report—that somehow there was something wrong with listening to evidence presented by the CCACs, or anyone else, suggesting that that structure should be changed. The committee has every right to hear that, but that would not be the focus of the report that we turn in to the Legislature.

Does that satisfy the need there? Okay.

With that, that was the only thing that I wanted to make sure was on the public record. We now will be going to closed session to review the LHIN report. As you can see, there are no delegations on for this afternoon. We are working on delegations, but we were unable to get them scheduled in for today.

The committee continued in closed session at 1411.

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SP-46

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ISSN 1710-9477

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of Ontario

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Official Report of Debates (Hansard)

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Journal des débats (Hansard)

Mardi 29 avril 2014

Standing Committee on Social Policy

Learning Through Workplace Experience Act, 2014

Comité permanent de la politique sociale

Loi de 2014 sur l'apprentissage par l'expérience en milieu de travail

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

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Publié par l'Assemblée législative de l'Ontario

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Tuesday 29 April 2014

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Mardi 29 avril 2014

The committee met at 1602 in committee room 1.

LEARNING THROUGH WORKPLACE EXPERIENCE ACT, 2014
LOI DE 2014 SUR L'APPRENTISSAGE PAR L'EXPÉRIENCE EN MILIEU DE TRAVAIL

Consideration of Bill 172, An Act to amend the Ministry of Training, Colleges and Universities Act to establish the Advisory Council on Work-Integrated Learning / Projet de loi 172, Loi modifiant la Loi sur le ministère de la Formation et des Collèges et Universités pour créer le Conseil consultatif de l'apprentissage intégré au travail.

The Chair (Mr. Ernie Hardeman): I call the Standing Committee on Social Policy to order, the meeting for Tuesday, April 29. We're here this afternoon to do public consultation—

Mr. Vic Dhillon: Chair, before the meeting, I have a motion that I'd like to put on the floor.

The Chair (Mr. Ernie Hardeman): First of all, I need to say what we're here for.

Mr. Vic Dhillon: I'm sorry, Chair.

The Chair (Mr. Ernie Hardeman): We're here to have public hearings on Bill 172, An Act to amend the Ministry of Training, Colleges and Universities Act to establish the Advisory Council on Work-Integrated Learning.

We have a full afternoon of committee, so the motion that you have will not be able to be put and dealt with until we finish the hearings because the meeting is set up to have public hearings. So we have that. You can table the motion with the Clerk, but it will not be dealt with today.

The second thing is, we have an issue that we need to deal with very quickly, and we will do that after the hearings are finished. Hopefully, we'll have a minute or two. The Clerk needs to address the committee in camera for just a few minutes.

STUDENTS AGAINST UNPAID INTERNSHIP SCAMS

The Chair (Mr. Ernie Hardeman): With that, our first presentation is Students Against Unpaid Internship Scams, Josh Mandryk, co-chair.

Josh, have a seat there. Thank you very much for taking the time to come and speak to Bill 172. You will have 10 minutes to make a presentation, and then we'll have 10 minutes to have questions and comments from the committee.

With that, the floor is yours for the next 10 minutes.

Mr. Josh Mandryk: Thank you. Members of the committee, it's an honour to be here before you today. It's a pleasure to speak on Bill 172, the Learning Through Workplace Experience Act. My name is Josh Mandryk, and I'm the co-chair of Students Against Unpaid Internship Scams. We're a group of students, youth, labour activists and others working to address the problem of unpaid internships in Ontario.

The focus of my presentation today is going to be on unpaid internships run through post-secondary programs in Ontario and the pressing need to take action to narrow the scope of these programs and the over-broad exclusion from minimum wage which they enjoy.

Experiential learning programs may offer invaluable experience to students in many cases, but may also offer little more than free labour to employers and the exploitation of young workers in many others. Unpaid internships, both inside and outside of the context of post-secondary educational programs, are displacing paid, entry-level jobs and are contributing to the growing youth unemployment crisis.

The youth unemployment rate in Ontario fluctuated between 16% and 17.1% in 2013, which is significantly higher than the national average. Addressing exploitative unpaid internships that are run through post-secondary educational programs must be part of a broader strategy to address youth unemployment and support young workers.

Section 3(5) of the Employment Standards Act provides that the act does not apply with respect to an individual who performs work under a program approved by a college of applied arts or technology, or a university. This provides a full-scale exclusion from minimum wage for all internships run through post-secondary programs. Our organization has a serious concern about the breadth of this exclusion.

This year, the Ministry of Labour began to take actions to proactively enforce the law and crack down on illegal unpaid internships run outside of the context of post-secondary programs. These are positive steps, but the Ontario government has failed to address the second pillar of the unpaid internship crisis, and that is the

proliferation of unpaid internships run through post-secondary programs.

Universities and colleges have failed to adequately exercise control over internships connected with academic programs. Recent media coverage has shown that it is not uncommon for college students to work as unpaid interns cleaning hotel rooms as a requirement of their academic program. These types of programs raise serious concerns about exploitation and the displacement of paid work.

We are concerned that as post-secondary educational institutions face their own budgetary crises arising from inadequate provincial funding, they are increasingly turning towards experiential learning programs as a way to collect tuition fees without having to spend funds associated with classroom instruction.

Furthermore, Ontario's colleges and universities are simply not doing enough to ensure that these programs are paid. When institutions do not push for paid programs, the inevitable default is that these programs will be unpaid.

Yesterday, April 28, was the National Day of Mourning for thousands of workers across Canada who have been killed, injured, or suffered illness as a result of work-related incidents. Today, as we consider the path forward for the regulation of experiential learning programs, we feel it's necessary to recognize the recent passing of Aaron Murray.

Aaron Murray was a 21-year-old Loyalist College student working an unpaid practicum placement as a security guard at Trent University. He was on his way home from an overnight placement shift when he crashed his car at 5:30 a.m. on April 3, 2014. Mr. Murray was the father of a three-week-old son at the time, and his situation highlights the double burden placed on unpaid practicum students, who are forced to work for free yet still have to earn an income to get by.

As the Toronto Star's Zoe McKnight reported, "The day before the crash, Murray had slept for a few hours after his overnight shift before heading to an afternoon shift at a Trenton McDonald's, where he is a manager. After a short break in the evening, he made the hour's drive back to Peterborough to check in for 9 p.m."

Mr. Murray's tragic death also raises other important concerns surrounding unpaid internships run through post-secondary programs. As the Star's Zoe McKnight reported, Mr. Murray's unpaid placement was as an overnight security guard at Trent University. The fact that this type of work would be conducted by an unpaid intern highlights both the displacement effect of unpaid internships as well as the shocking lack of oversight and regulation over what is and what is not an appropriate unpaid internship through an academic program.

Students Against Unpaid Internship Scams welcomes Bill 172 as having the potential to help the Ontario government address the proliferation of exploitative unpaid internships run through post-secondary programs. We welcome the proposed advisory council as an important opportunity for input from students and labour organizations, but caution that the advisory council must immediately address the proliferation of unpaid internships through post-secondary programs and work towards increasing the share of these programs that are paid. The status quo on experiential learning programs is not working.

As part of the advisory council's mandate, the proposed section 3.1(6)(a) states:

"The council shall,

"(a) advise the minister with respect to ways to increase work-integrated learning opportunities, particularly paid opportunities;"

We appreciate the emphasis placed on paid opportunities in this section. In our opinion, however, it does not go far enough. Accordingly—and this is in our submission, which has been given to all of you—we propose the following amendment to the proposed section 3.1(6)(a). As we would prefer it, it would state,

"The council shall,

"(a) advise the minister with respect to ways to:

"(i) increase paid work-integrated learning opportunities, and

"(ii) improve the regulation and oversight of unpaid work-integrated learning opportunities, with the aim of limiting the overall proportion of work-integrated learning opportunities that go unpaid;"

This amendment will empower the proposed advisory council to effectively address and make recommendations regarding the rise of unpaid internships run through post-secondary programs.

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More broadly, we stress that the advisory council's focus should not simply be on expanding the number of experiential learning programs, but also ensuring that current programs are meritorious, that they are beneficial to students and young workers, and that they come with appropriate remuneration. Strong evidence suggests that this is not the case in many instances.

In conclusion, I'd like to stress my strong belief that the biggest issue surrounding experiential learning programs in Ontario right now concerns the rise of unpaid internships that exploit young workers and displace paid employment. The Ontario government must provide greater oversight and shift towards a paid-first approach that reduces the proportion of students forced to engage in unpaid labour through their academic programs.

I'd like to reiterate our organization's support for Bill 172. We welcome it as having the potential to help Ontarians take a step in the right direction regarding experiential learning programs. In order to fulfill this potential, however, the proposed advisory council must be given a clearer mandate to address unpaid internships run through post-secondary programs and to work towards increasing the share of these programs which are paid.

Thank you very much, and I'm happy to answer any questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We'll start the questions with the third party. Ms. Sattler.

Ms. Peggy Sattler: Thank you very much for the presentation.

As you know, and as the legislation describes, there are a number of different kinds of opportunities that can be defined as work-integrated learning, internships being one. Your presentation focused on unpaid internships. Would your concerns apply equally to the other types of work-integrated learning—field placements, practicums, service learning, all of those other things?

Mr. Josh Mandryk: Not all are created equal. That's why we have to be careful and that's why our organization certainly isn't advocating for you to ban completely all unpaid experiential learning programs. That's certainly not the case.

I'm a law student, and I know that at our school we do placements at legal aid clinics. These are volunteer placements or credit placements which are not paid, and I feel that's appropriate, that they're unpaid there.

So certainly we're not pushing in all circumstances for these programs to be paid, but we do think that greater oversight needs to be made, because in a lot of these circumstances, we're seeing positions arising which would have traditionally been paid and are now not, and there is a problem about displacement. I think this bill intends to look at that stuff, and I think there is language around there about preference to paid positions, but in our position, we would like it to be just a bit clearer.

Ms. Peggy Sattler: Thank you. You mentioned at the beginning about your focus on unpaid internships, both inside and outside post-secondary education. Do you have a sense of what the prevalence is of unpaid internships inside the post-secondary sector versus outside?

Mr. Josh Mandryk: Unfortunately, there are not official statistics on this. I know your colleague Jonah Schein has put forward a bill to track the number outside of post-secondary programs, but we're not certain.

Ms. Peggy Sattler: Okay. Now, you mentioned the actions that have been taken by the government to enforce employment standards for interns. Can you talk a little bit more about what other actions you think should be taken to address those concerns?

Mr. Josh Mandryk: Outside of the post-secondary context, we've seen some measures of proactive enforcement, and we've seen announcements that there will be more. We think that's all positive.

Turning more towards the content of this bill, as mentioned, there's a broad exclusion for all unpaid internships run through post-secondary programs. We have a concern that there is not enough oversight and that more guidance needs to be put forward about what is and what is not appropriate for an unpaid position. I think this bill can step us towards having that oversight, and I think the advisory council could be a useful tool for doing that.

Ms. Peggy Sattler: How much more time do I have?

The Chair (Mr. Ernie Hardeman): Just about a half a minute left.

Ms. Peggy Sattler: The legislation defines or gives some characteristics of work-integrated learning in section 2. Do you feel that those characteristics are appropriate to define work-integrated learning?

Mr. Josh Mandryk: Yes. I think that it's very important. I think also, the parts in that section about having the requirements spelled out beforehand and the expectations—I think that's all very important.

Ms. Peggy Sattler: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for that.

We'll go to the government. Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you for being here. I'm glad you mentioned the internship of yourself in the law program, in the legal aid clinics, because my own son did it. It was a great learning experience, and I don't think money was the factor at all for him. So now that you've clarified that, can you talk about what you mean by oversight in the cases where it's unpaid? What are you expecting to achieve and what can be done?

Mr. Josh Mandryk: I think the advisory council can be a useful tool for spelling that out exactly. Given the mandate, the advisory council can help clarify that. But what we're seeing is that the current exclusion pretty well leaves it to the colleges and universities to figure out what is and what is not an appropriate unpaid position. Particularly in the colleges, you're seeing positions that are just clearly inappropriate, as the Star's Zoe McKnight has reported, positions in hotels doing cleaning jobs and things like that, which certainly most folks would agree aren't appropriate for an unpaid internship. That's just work that's being displaced by a student, and even worse, the student is forced to do this and, often, has to pay tuition for it.

Guidance needs to be done, but we think that the advisory council could help provide some of that guidance and flesh out better what is and what is not appropriate. But certainly, from the ministry, there needs to be some clear guidelines.

Mr. Bas Balkissoon: But what if it's a case—I know of an example with a community college that I'm familiar with, where the students who are in the hospitality program often will work on a banquet, they organize the banquet, they actually serve the patrons and they do all this stuff. They have a post-mortem where they actually look at all the logistics they went through and critique what they've done. What happens if those students volunteer because they see it as a good learning experience? Are you saying that that should not happen? How is that any different than your law program?

Mr. Josh Mandryk: Well, again, some of the specifics and the really close details do need to get fleshed out, somewhere other than at this committee. But I think, speaking to hospitality and things like that, a lot of these positions are not what you're talking about. They're not a one-off thing, where folks reflect on it after, but rather, they're positions where folks work in a hotel or work as a dishwasher or work doing laundry for hundreds and hundreds of hours. That's just displacing paid work. Look at Aaron Murray, who recently passed away. He was working as an overnight security guard on a univer-

sity campus. To me, that's shocking that that was an unpaid internship. You would think that would be a good-paying job.

I'm not here advocating that every single unpaid position become paid. That's not feasible and, in many cases, it's not appropriate. But certainly, it does need to be narrowed.

Mr. Bas Balkissoon: But who will be the judge and jury to determine which ones should be paid and which ones should not be paid?

Mr. Josh Mandryk: Well, I think it would be fantastic if this advisory council could put forward some very clear guidelines and regulations, which colleges and university programs could then apply.

The Chair (Mr. Ernie Hardeman): Thank you very much. Mr. Chudleigh.

Mr. Ted Chudleigh: Thanks for coming in today. I think what you're advocating for is oversight, and it's where that oversight should take place that kind of interests me. If the college or university or the learning facility—they certainly should have some responsibility for that oversight. Are you suggesting the government should have the oversight of the university or college and program that they do?

Mr. Josh Mandryk: I think we're seeing that a lot of especially college programs, but some university programs, have proven themselves irresponsible in this manner and have, in many cases, proven themselves a partner in these programs which appear to be very exploitive. As I touched on before, I think a lot of colleges in particular are feeling squeezed and they're seeing these programs as a way to reduce their own costs and to get tuition fees at the same time. We're certainly seeing a rise of a number of programs which are deeply problematic, and that suggests to me that the colleges on their own have failed in the regulation of these and that they need greater guidance.

Mr. Ted Chudleigh: Have you seen any of these examples in, for instance, private colleges?

Mr. Josh Mandryk: I have not been in contact with folks in private colleges. I'm here in Toronto, so I've been talking mostly with folks in Toronto colleges and universities.

Mr. Ted Chudleigh: There's a huge number of private colleges in Toronto.

Mr. Josh Mandryk: Yes.

Mr. Ted Chudleigh: So the initial responsibility, you think, lies with the universities and colleges, but is the ministry of universities and colleges not exerting any oversight in those areas?

Mr. Josh Mandryk: Not sufficiently.

Mr. Ted Chudleigh: Not that you're aware of?

Mr. Josh Mandryk: Not sufficiently. I think we looked at the broad exclusion from payment for all of these internships, which is too broad and needs to be narrowed.

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Obviously, this is an issue that overlaps between post-secondary education and labour and employment, and the ministries need to perhaps work together on this, but certainly the MTCU needs to provide more guidance.

Mr. Ted Chudleigh: Your main thrust, though, is oversight?

Mr. Josh Mandryk: Yes.

Mr. Ted Chudleigh: Good. Thank you very much for coming in.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It was much appreciated.

Mr. Josh Mandryk: Thank you.

ONTARIO UNDERGRADUATE STUDENT ALLIANCE

The Chair (Mr. Ernie Hardeman): Our next presenter is the Ontario Undergraduate Student Alliance: Sean Madden, executive director. Thank you very much for joining us this afternoon. As with the previous presenter, you will have 10 minutes in which to make your presentation, and then we'll have questions and comments from the caucuses, this time starting with the government caucus. With that, the next 10 minutes is yours.

Mr. Sean Madden: Good afternoon. Thank you for having me, and thank you for having the Ontario Undergraduate Student Alliance before you today.

My name is Sean Madden, as mentioned, and I am the executive director of OUSA. We represent over 140,000 undergraduate and professional students through our eight member institutions across Ontario.

OUSA advocates for an affordable, accountable, accessible and high-quality university education in Ontario. This mandate has expanded into easing the route of students out of post-secondary education as well as in. Students, more than ever, are concerned about parlaying their education into a job or career upon graduation. They're also very interested in strategies for paying for school and mitigating debt while doing their studies.

Work-integrated learning, or WIL, represents an important opportunity to address both of these concerns, particularly in disciplines where existing WIL opportunities are lacking. Research indicates that students who undertake a paid work-integrated experience have better employment outcomes, earn starting wages that are $2 to $3 higher than those with unpaid placements or no WIL experience, and, unsurprisingly, graduate with less debt than their peers.

Among employers who offered work-integrated learning and were able to hire full-time employees, 82% hired someone who had completed a WIL experience with them. Of all employers who hired college or university graduates, over 60% offered employment to candidates who had some form of work-integrated learning experience.

Just as importantly, OUSA focus groups have found that students who had undertaken even one work-integrated learning experience told us that they felt more confident in applying for work through an enhanced understanding of the skills developed by their education and a stronger ability to communicate those skills to employers.

Work-integrated learning has proven successful in those university fields that you might already associate with it: engineering, finance and accounting, computer sciences. Further, the largest provider of university co-operative education in our province, the University of Waterloo, has been able to provide well over 90% of their placements as paid opportunities, with a commitment to reach 100% in just a few years, showing that it is possible to find good paid experiences.

If I might address MPP Sattler's earlier question about internships within institutions, a recent OUSA survey found that of all people who had undertaken a work-integrated or experiential learning opportunity, 12% reported one of those experiences being an unpaid internship.

Bill 172 sets a positive direction for work-integrated learning in Ontario. We want to thank MPP Sattler for undertaking this bill and for consulting OUSA as part of the process.

Delving into the bill itself, the principle of ensuring that each student in a program offering work-integrated learning is given an opportunity for an appropriate placement is important to a more equitable and economically strong society, as low-income students, aboriginal students, students with disabilities or otherwise disadvantaged students can be under-represented in work-integrated learning while simultaneously having the most to gain.

We want to again thank Ms. Sattler for recognizing the importance of student representation on the Advisory Council on Work-Integrated Learning and to express that we look forward to doing our part in fulfilling its mandate as a member.

Further, work-integrated learning opportunities are a core component of many college programs, and we expect that their example and the inclusion of the College Student Alliance in these discussions will offer some positive lessons in growing work-integrated learning within the university.

The committee's mandate contains many activities that OUSA has identified as important to enhancing and expanding work-integrated learning. In particular, a focus on paid opportunities should remain a priority for the council and the province. Recent findings indicate that not only do unpaid internships create situations favouring students from higher-income backgrounds, thereby creating inequities in important industries, but they also do not provide a lot of the opportunities that they are purported to. In fact, students who have undertaken unpaid internships were only marginally more likely to be employed than those who had undertaken no work-integrated learning, and the average earnings were actually slightly less.

In the interim, however, we want to recognize the government, as well as all engaged MPPs, including MPP Jonah Schein, for expanded enforcement in illegal internships, as well as seeking to expand protections for legal unpaid interns. I think the spirit of Bill 172 is to ensure meaningful opportunities based on learning outcomes for all students, and it's heartening to see that spirit broadly embraced by all parties. We want to encourage that continued direction.

We also believe the bill does a good job of recognizing the informational barriers that remain a leading cause of an employer deciding not to offer a work-integrated learning opportunity. Both the mandate to increase awareness amongst employers and to contribute to the design of a Web resource are important steps to reaching into an untapped group of potential employers, including those who are unaware of the existence of such programs altogether; those who might not know the benefits of taking on a co-op or other work-integrated-learning student, or the supports available in doing so; or even those who simply might not feel that they're equipped to provide an impactful educational experience.

One of the most promising areas of the bill is empowering the council to explore incorporating work-integrated learning across disciplines. We have identified that the arts, humanities and social sciences, as well as hard sciences, are underrepresented among Ontario students who have experienced a work-integrated learning opportunity and may be over-represented amongst unpaid work-integrated learning placements. There is a belief among university staff who facilitate work-integrated learning that a lot of the easy placements have been made and that programs in engineering and finance have achieved a much higher degree of interest and outreach from employers, and that in turn contributes to their continued existence. Professionals in this area note that small to medium enterprises, and in particular those that might benefit from a student from one of these under-represented disciplines, may be even more unaware of work-integrated learning placements, their benefits and programs of support, and are almost certainly less able to facilitate such placements.

Of all the students participating in co-operative education, for example, nearly half are engineering or business students, while only 4.5% are from the hard sciences and 12% are from the arts, social sciences and humanities combined. Expanding the capacity of these small to medium enterprises to take on even one student as a trial, or expanding opportunities for these underrepresented disciplines in larger enterprises, has the potential to vastly improve the educational employment prospects of these students.

Finally, better monitoring and reporting in the area of work-integrated learning in Ontario is key to making effective decisions and remaining responsive to the problem of youth employment. OUSA fully supports a comprehensive and transparent treatment of data relating to any education initiative in the province and eagerly awaits the findings of increased oversight of WIL.

Based on everything I've said, it's probably no surprise that OUSA acknowledges Bill 172 as an important step in enhancing not only the educational experience of students but also their employment prospects. We also firmly believe that broadening the availability and accessibility of work-integrated learning will have positive

impacts for those enterprises that participate and the province as a whole.

We look forward to this bill's passage and to working with the advisory council in the next steps.

Thank you again for the opportunity to address you all today. I would welcome any questions that you might have.

The Chair (Mr. Ernie Hardeman): Thank you very much. The questions, as I said, are with the government. Ms. Wong.

Ms. Soo Wong: Welcome, Mr. Madden. Thank you for coming today. With respect to your organization, what are some of the successful examples of work-integrated learning, that you would like to share, that we should be advocating and replicating across the province?

Mr. Sean Madden: Wherever possible, a work-integrated learning opportunity—I guess this isn't a specific example, but rather a specific practice. Any work-integrated learning opportunities that clearly establish learning outcomes to be met by both the employer and the participant tend to be those best ones, ones with frequent check-ins, ones that identify activities based to those learning outcomes.

In some of the ones we've seen, a relatively high degree of independence tends to be helpful. Some of the most encouraging ones we've heard about, particularly related to this idea of under-represented disciplines, are actually in the not-for-profit, or NGO, sector, where these work-integrated learning opportunities allowed them to build capacity in a direction that they previously didn't have, and a lot of that ownership belonged to the student participating.

Ms. Soo Wong: I believe your organization shared with the committee a couple of recommendations here. In one of them, you indicated that you want to amend the Employment Standards Act related to protecting students in work-integrated learning. Has your organization spoken to the Ministry of Labour and the minister with regard to this recommendation?

Mr. Sean Madden: Yes, both. I know there were to be some working groups going forward with the Ministry of Labour. Understanding that there was some change over there recently, we're looking forward to moving forward with those.

We've had discussion with all parties about these. In general, what we're asking for is the removal of the blanket exemption that exists within the Employment Standards Act for university- or college-facilitated unpaid internships and, rather, the application of the six-point criteria that already exists in determining an unpaid internship within the Employment Standards Act.

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Ms. Soo Wong: Now, the other recommendation you put out to us is the fact that you put a target of the co-op placement opportunity by 10% over the next five years, specifically dealing with the under-represented disciplines. How do you come about with this 10%?

Mr. Sean Madden: That was actually a topic of some discussion. We had originally started with addressing the idea of a hard number of participants. What I mean by that is matching the amount of participants from these under-represented disciplines to the actual hard number of participants within the business and engineering fields. We realized that that might be a little bit too small. So we looked at matching participation rates, and we decided that might be a little bit too big.

The incentive program that we had discussed, as you see before you, was to provide funds for the creation of placements in each of these disciplines. But with, of course, arts and humanities being a bigger discipline, getting that participation rate up to, say, that of business or engineering would be prohibitively expensive. So after some back and forth, our students decided that 10% growth would go some way towards matching the frustrations we hear from students in those disciplines about limited availability. The number was meant to be both economical, from the province's perspective, in not costing the same as bringing all participation rates up to high-participation disciplines, while still, we think, addressing some of the need.

The Chair (Mr. Ernie Hardeman): Thank you very much for that. The official opposition: Mr. Chudleigh.

Mr. Ted Chudleigh: Thanks very much for coming in. I think what I'm hearing from you is that you think that there should be a better job done of matching students to the experience. Maybe that's the universities' problem, maybe it's the colleges' problem, maybe it's the government's problem, or maybe it's the students' problem. Heavens, we don't know about the students' problem.

I had a student from Ryerson University who came in as an intern. She was here for 10 weeks, about one afternoon a week, about four or five hours. The first day we went through a little bit of work organizing 10 different areas she would look into and have some experience in in this Legislature. She got an A in the course, but I never had any contact with the university or its professor or any of his assistants. It was entirely up to the student. What would be your comments on that?

Mr. Sean Madden: That's certainly not the ideal. Certainly, students have some idea of what they hope to take away from it. But when you're talking about as part of a complete educational perspective, there are some end game outcomes that a university or college would like to see the student get. It's unfortunate that you didn't have that contact. It sounds like you did a good job of addressing learning outcomes, and it is our hope that any employer would, but a lot of employers are a little bit freaked out or unsure about how to frame those learning outcomes. Certainly, there's a little bit more room, and hopefully the advisory council would help universities to better communicate that.

Mr. Ted Chudleigh: There comes a time in every student's life where they can't rely on other people to do what they have to be doing, eventually, themselves. You're suggesting that this isn't one of those times.

Mr. Sean Madden: Well, in terms of an employer relationship, I don't know if you want the majority of

situations to be the employee determining their outcomes either. We see that relationship being designed and creating the expectation and the understanding that you can effectively communicate with an employer to produce what's needed. I don't think that's any different in the work or university environments.

Mr. Ted Chudleigh: There's an intern program—different than the one that I was involved in—in the Legislative Assembly here where there are 40 or 50 interns who come in and spend three or four months with an MPP with the government and then they spend three or four months with an MPP outside the government. In my experience, over almost 20 years of being here, I think none of them have ever become MPPs. They've had a wonderful experience, and they've decided to go elsewhere in their lives.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes your time, and you didn't leave an opportunity for an answer.

The third party: Ms. Sattler.

Ms. Peggy Sattler: Thank you very much for the presentation, Sean. You talked about focus groups that you've organized through OUSA with the students you represent. Do you have a sense of what kind of level of interest there is among students more generally? Also, what are some of the barriers that students face if they are interested in participating but haven't?

Mr. Sean Madden: Absolutely. I can definitely say that there's some frustration that placements aren't available in these under-represented disciplines or in a particular area of study, or even in a particular course that seems to sort of be begging for it. We've definitely heard that. Sometimes that's motivated by, as MPP Chudleigh pointed to, figuring out what it is you want to do or not want to do, whether it be an MPP or not. Sometimes it's a financial frustration.

Some of the barriers, then, are similar. Sometimes a professor doesn't have sufficient resources or sufficient understanding, or even efficient communication with the people responsible for arranging co-op placements, and so may not be proactive in seeking that out for a particular course or area of study.

Other times, a student might feel that they don't have the financial resources to undertake it, as sometimes co-operative fees, as mentioned by the preceding speaker—sometimes it's expensive to participate in these programs, whether it be a co-op fee or the expectation that you're going to give up some income in order to undertake an unpaid, but educationally impactful experience. Other times, the students themselves might be hesitant to undertake this experience, thinking that they're not equipped to work in that environment or learn in that environment. I think probably two thirds of your barriers are informational and one third is probably financial.

Ms. Peggy Sattler: Okay. You mentioned that in these focus groups, students that you talked to reported that even those with only a single experience still felt that it was a valuable part of their post-secondary program. Those aren't all with co-op experiences, though, I gather.

Mr. Sean Madden: No.

Ms. Peggy Sattler: Your recommendations on the sheet that we've been handed refer specifically to co-operative learning, but is it your sense that the other kinds of work-integrated-learning programs offer benefits that are comparable to co-op?

Mr. Sean Madden: Absolutely. As I mentioned, sometimes unpaid experiences don't seem to translate to an employer in terms of value, but from the students, we hear quite clearly that a small placement, be it one to five hours a week, an experiential learning opportunity, be that in classroom or field placement or a community service learning or service-based opportunity, all contributed to helping them figure out what they wanted to do, allowed them to apply their education in sometimes surprising ways to themselves, and to feel a little bit more comfortable in any sort of work environment.

The Chair (Mr. Ernie Hardeman): That concludes the time. Thank you very much for your presentation.

Mr. Sean Madden: Thank you.

CANADIAN FEDERATION OF STUDENTS–ONTARIO

The Chair (Mr. Ernie Hardeman): Our presenter is the Canadian Federation of Students–Ontario: Anna Goldfinch, Ontario national executive representative. Welcome, and thank you very much for being here this afternoon. You will have 10 minutes to make your presentation. That 10 minutes starts right now.

Ms. Anna Goldfinch: Thank you. Hello, my name is Anna Goldfinch, and I'm the national executive representative with the Canadian Federation of Students–Ontario. Our organization represents full- and part-time college, undergraduate, graduate and professional students from anglophone, francophone and bilingual institutions across Ontario. We are the oldest and largest student organization in the province.

In my work with the federation, I travel from campus to campus talking to students about their experiences within the post-secondary education system. More and more, we are hearing that students in Ontario are working for free. It seems that it's now only every few weeks that we see another personal interest story about some poor student working two jobs, going to school and holding an unpaid co-op, who has hurt themselves on the job because of exhaustion, is filing a complaint for back wages or has to drop out of school because they just can't afford it.

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Today, students in Ontario pay the highest tuition fees in the country. To finance these ever-increasing fees, they are more in debt than ever: $37,000 is the average debt for those who take on student loans in this province. That's the average. And now, increasingly they are expected to work for free.

A recent study published by the Canadian Centre for Policy Alternatives has shown that it takes 2.7 times as many hours worked at minimum wage to pay for a year

of university in Ontario than it did in 1975. This means that what took my parents around a month to earn when they were in university now takes me an entire summer working at full-time minimum wage.

When students can't even earn enough to pay for tuition after a whole summer of work, it comes as no surprise that they struggle to pay for everything else, like books, rent and food. We only have to look at the skyrocketing number of students frequenting campus food banks in Ontario to know that this is the case.

I paint this picture not to be the bearer of bad news but to articulate the importance of paid work for students at a time when they desperately need to finance their education but are consistently being asked to work for little or no compensation.

It has become all too common in all sectors to expect this kind of free work from students during their degrees. Sometimes working for free is a required credit course that students must take if they want to graduate. Time, for students, like all of us, is a zero-sum game. Being forced into unpaid internships and co-op placements means that we have less time to work at paid employment.

Unfortunately for most students, working to be able to afford school is a non-negotiable, so they must work the same amount of paid hours plus the additional unpaid hours at their placement or practicum. You can only imagine what type of pressure this puts on the remaining time that students have to study, not to mention eat, sleep and fulfil family obligations.

This bill takes a step in the right direction to begin the conversation about increasing paid work-integrated learning. Students in Ontario would benefit from work where they are gaining important hands-on experience without being expected to work for free.

This conversation is an important one. Up until December 2013, interns, trainees and co-op students were not even covered under occupational health and safety laws, putting the health and safety of thousands of students at risk. We need to be doing more to ensure that students are not exploited through unpaid internships, placements, practicums and co-ops.

Now, not only are students working for free, they're currently paying to work for free. Many institutions charge tuition fees for placements because they are for-credit courses, despite the fact that students are working and not going to school. Additionally, at some institutions, the co-op or placement office is a cost-recovering service and students are charged astronomical fees to simply gain access to their database of job postings. These fees, whether they are charged through tuition or a service fee, are a barrier to experiential learning and should be eliminated.

Our first recommendation would be to eliminate these fees associated with experiential learning.

One of the places where students work the most for free happens to be in the broader public sector. Students in a wide variety of social service programs such as nursing, nurse practitioner programs, social work, education and community support work, often complete mandatory unpaid work terms within the public sector in order to receive their degrees, diplomas and certification.

Many of these placements are run through academic programs at public colleges and universities. And even though they're run that way, the Employment Standards Act does not govern them. Many institutions also force students to pay partial or full tuition fees in order to work for free. In other situations, students already working in paid positions related to their field of study are told that they must log a certain amount of unpaid hours at their job before graduating.

While institutions and government contend that these unpaid internships are crucial to train various public servants, it is extremely uncommon for any employer to decline paying workers while they are training for a new position.

The broader public sector can lead by example to ensure all students training to work in the public service are paid for the work that they perform. By instituting paid internships, placements, co-ops and practicums in the public service, the government would be supporting a generation facing unique challenges and obstacles while setting an example for the private sector employers to follow.

Recognizing that the scope of this bill is solely within the purview of the Ministry of Training, Colleges and Universities, we would recommend that the council created through this bill would be able to work with other government departments to eliminate unpaid co-ops, placements and practicums in the broader public sector.

This bill and the council it creates is a step in the right direction. Students welcome amendments that will strengthen its mandate and widen its scope to eliminate all unpaid internships, co-ops, placements and practicums not only in the broader public sector but for all students in general.

Representing over 350,000 students in the province of Ontario, with undergraduate, graduate, college and professional students, the federation is extremely familiar with the effects of unpaid co-ops, placements and practicums and the effects that they have on students. We will be happy to continue to consult on this bill and participate in the committee when it moves forward. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. The questions will start with the official opposition. Mr. Chudleigh.

Mr. Ted Chudleigh: I take it your position is that all interns should be paid?

Ms. Anna Goldfinch: That's correct.

Mr. Ted Chudleigh: I thought so. No further questions.

The Chair (Mr. Ernie Hardeman): Okay. The third party: Ms. Sattler.

Ms. Peggy Sattler: Your organization represents both undergraduate students and graduate students. I wondered if the issues around work-integrated learning are different from the perspective of those two groups of

students. Are there differences between undergrads who participate in these programs versus graduate students?

Ms. Anna Goldfinch: There are some differences, but primarily there are a lot more similarities than differences. For example, students who might be taking a master's of social work program will also have to engage in co-op work, as well as whether they were doing a bachelor's degree. Usually, when you're moving forward, you need to log more hours.

For example, at the co-op office at my alma mater, Carleton University, both graduate students and undergraduate students use the exact same service and pay the same fees. If you wanted to engage in a co-op placement, you would have to pay the fees in the cost-recovering program to access the job bank and then pay an additional amount of money every time you accessed a job. It was $400 to access the job bank and then $400 every time you succeeded to gain employment, and that was for graduate students and undergraduate students.

Ms. Peggy Sattler: And that's an example of the kind of fees that you would like to see eliminated around work-integrated learning.

Ms. Anna Goldfinch: Yes, absolutely. That's a perfect example. These aren't just tuition fees; they're additional service fees.

Ms. Peggy Sattler: Right. Now, you talked about the need to ensure that students who are participating in these programs are not exploited. The legislation refers to the mandate of the council to work with post-secondary institutions to ensure the quality of these placements. Is that enough, or do you think that the bill should do more to address the potential for exploitation of students?

Ms. Anna Goldfinch: I think it's a step in the right direction. Using an example from OCAD, just down the road from here, they've actually instituted a policy whereby they won't put up any co-op placements for their students if they're unpaid, which means that they are promoting the fact that their students are very skilled, and if they're going to put them out there, they should be paid for that work.

I think it's a good start to be asking post-secondary institutions to set a good example, but oversight from the province would be able to ensure that no student is being overlooked just because their institution decided not to go that way.

Ms. Peggy Sattler: Okay. You said that CFS would obviously be very eager to participate in this council, if it moves forward. What kind of work do you see your organization doing if this council is created and you would have a voice at the table?

Ms. Anna Goldfinch: Well, what we do best is representing students. I spend each day—most days—on the ground, talking to students.

Bringing the fact that we are the largest student organization in the province and we represent all types of students in the province, we would be able to bring a perspective for undergraduate, graduate and professional students both from universities and colleges. As well, the fact is we do a lot of our own research on unpaid internships, work terms, that type of thing.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Wong.

Ms. Soo Wong: Thank you very much for your presentation. I just want to go back, because you made a comment with respect to some of the health-related professions. With respect to the nurses, I want to have a conversation with you with respect to—has your organization checked with the College of Nurses with respect to the fact that the nurses in Ontario must have X number of hours of training before they can graduate?

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Ms. Anna Goldfinch: Yes, absolutely. We understand how the policy works, but we're looking for a shift in the way that we conceptualize the practicum work that nurses do in our health sector. What we believe, and what nursing students believe, is that the work that they're doing is contributing to our health sector. Although they do need to log a certain number of hours in their practicum to become a registered nurse, it's very important as well to be compensated for the work they're doing and the contribution they give to our health sector.

Ms. Soo Wong: Can I get some clarification? Who should be compensating? Is it the employer where they get the training from, or the university or colleges where they're currently a student?

Ms. Anna Goldfinch: It would be through the employer. I think that this goes to show and sets up exactly what I'm saying: that these students are contributing to a workplace while they are being trained. In a lot of cases in the private sector as well, when employees are being trained, they're also contributing to that workforce and so they're paid by their employer.

It's important that, especially in the health sector and in all of the broader public sector, we're recognizing the work these students are doing and that their employers are paying them for it.

Ms. Soo Wong: Okay. The other thing I was going to ask you is: How do you work collaboratively with the employer with respect to giving students opportunity, because there's that whole gamut of education and where not all employers would be supportive of having students in the workplace because they may see that as adding extra work? So how is your organization advocating in terms of educating, an improvement of that awareness, the importance of work-integrated learning?

Ms. Anna Goldfinch: I think that's a great question. I think it's something that this committee, when set up, would be able to work on and be able to produce some sort of guide that allows educational institutions to work with employers, to give them a set of best practices. We have those six criteria around internships, but I think we need to go further than that. I know that some co-op offices do workplace check-ins. That's something that should be available to students.

It should be an environment wherein the employer going into this co-op or placement or practicum is clear on what the work-integrated learning is going to be, and it's the same on the side of the students, so that there's some sort of mutual understanding.

Ms. Soo Wong: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for making the presentation this afternoon.

COLLEGES ONTARIO

The Chair (Mr. Ernie Hardeman): Our next presenter is Colleges Ontario: Bill Summers, vice-president of research and policy; and Cheryl Jensen, vice-president, academic, Mohawk College.

Thank you very much for being here this afternoon. As with the previous delegations, you will have 10 minutes for your presentation and then we'll have questions and comments from the caucuses. This time, we will start with the third party. Your 10 minutes start now.

Mr. Bill Summers: Thank you very much for having us here today. We're delighted to be able to talk to the committee about this bill. My name is Bill Summers. I'm vice-president of research and policy at Colleges Ontario. With me today is Cheryl Jensen, who's vice-president, academic at Mohawk College. As you may know, Colleges Ontario represents the 24 publicly funded colleges throughout the province.

Before I begin my remarks, I'll mention that we're just tabling a report with you that we released last fall. It's really an overview of much of the great work that the colleges do throughout the province to develop a skilled workforce. Because experiential learning is at the core of everything we do, you'll find that many of the examples involve working with employers to have a workplace component of the program. So I'll just leave that with you as background.

On behalf of the 24 public colleges, we are delighted to be here today to talk with you about Bill 172 and the importance of experiential learning in Ontario. We'd like to congratulate MPP Peggy Sattler on the introduction of this important piece of legislation and would like to commend the committee for your work.

This issue, as you know, is very important to students, parents, business leaders and the province as a whole. As you know, we face significant challenges in Ontario. We are struggling with a youth unemployment rate that is much too high. We also have a significant underemployment problem. Far too many young people are working at jobs that don't properly utilize their talents and skills, but we can't ignore the fact that, even in this economy, there are many good-paying positions that can't be filled. Quite often, that's because the young people seeking work don't have the necessary qualifications and advanced skills. There is a significant skills mismatch problem in this province. We know that there are many young people who could be making more of a contribution to Ontario's prosperity. With the right skills and the right education, many of them could find work that is even more meaningful than what they're finding now. So it is important to focus on experiential learning and to determine what Ontario can do to strengthen our workforce through this strategy.

Ontario's colleges, as I'm sure you are very aware, are leaders in this area of experiential learning. Work-integrated learning is at the very core of the education delivered by the province's 24 public colleges. We believe that integrating classroom academic learning with real-world experience encourages active learning and equips students to realize their personal and career goals, making them productive, civic-minded members of society.

Colleges offer many forms of work-integrated learning, ranging from, of course, our great role in apprenticeship training in many, many occupations; co-op placements in business and technology; clinical placements in our health science and social service programs; and a growing number of applied research projects with industry partners in many of our degree programs.

We recognize that successful work-integrated learning depends upon a three-way partnership between the employer, the college and the student. Colleges have established practices to create positive partnerships that value and aid student learning. I would like to just take a couple of minutes to highlight a few of those practices that colleges follow.

We want to ensure that students are fully integrated into the full environment of the workplace. This means, for example, that students should be included in many of the activities that regular staff would be involved in, including training and other opportunities. Colleges work with employers to ensure that the students receive orientation at the start of the placement and, at the end, an evaluation that reflects the progress that the student has made in meeting the established outcomes. We believe that students are active participants in work-integrated learning and should have a clear understanding of the expectations of both the employer and the college. So we welcome the introduction of Bill 172 and the move to highlight the importance of work-integrated learning.

We do, however, have at least one reservation about the bill—a small one, though. We do wonder whether there are some risks, in terms of using limited resources effectively, about the creation of the website to list post-secondary programs and courses that have this component. It's not clear to us what added value the website in Bill 172 would bring to students. Such a website would not likely be the primary source of information on work-integrated in the post-secondary sector, and there's the risk that it would only duplicate the information that is already available and would, of course, add a workload burden both because of the need to upload, but more importantly to maintain, the information in a current format.

More broadly, it will be important for MPPs and government to look at how Ontario can strengthen education and training to create a greater emphasis on experiential learning. We must promote the full range of careers available today, including the many well-paying careers in technical areas and the skilled trades.

We believe that one of the most important steps that Ontario can take is to look at the credentials that are

granted by the colleges. Ontario is somewhat unique. While our colleges offer some four-year degree programs, most of our programs grant diplomas and certificates. In fact, we must award diplomas to graduates of our three-year programs. This situation in Ontario is unusual. In most OECD countries, graduates of three-year post-secondary programs, including career-based programs, earn degrees rather than diplomas.

It is not clear why Ontario is different. In fact, many of our three-year programs are already aligned with provincial and national standards for degree programming. The students are meeting degree-level standards; they deserve to earn credentials that properly reflect their achievements and allow them to be competitive both within Ontario and beyond. A growing number of employers are seeking graduates who have degrees and who also have the advanced career-specific skills.

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We know that Ontario is aware that Ontario's colleges have the capacity to deliver high-quality degree programs. Several years ago, the province engaged a consulting firm to examine the role of colleges in degree granting. The study found that college degree programs were exceptionally strong in providing graduates with access to challenging careers in many fields, such as aviation technology, software development and industrial design, and that all of these programs included a core workplace-integrated learning component of at least one to three semesters.

We believe that Ontario should build on those successes, and we think that post-secondary education in Ontario should move to international standards by allowing colleges to offer three-year degrees. We believe that this will attract a greater number of students to colleges and thereby help produce more graduates with high skills in programs that include experiential learning as a core component.

I'd now like to ask Cheryl to take a few minutes and talk about her experiences at Mohawk.

Ms. Cheryl Jensen: Thank you, Bill. Just to give a couple of points on what we do at Mohawk: Mohawk is a leader in work-integrated learning. Many colleges focus on this as well. We were one of the first colleges in Canada to offer co-operative education, in the early 1970s. We currently have 27 programs with formal co-ops and manage more than 2,900 students in co-op work terms each academic year.

One of our leading examples is a partnership that we have with ArcelorMittal Dofasco in Hamilton, where we have co-op diploma apprenticeship programs created by Mohawk, our industry partners and the Ministry of Training, Colleges and Universities. These meet the needs of students, employers, our college and the government. Mohawk is the largest trainer of apprentices among Ontario colleges, and ArcelorMittal Dofasco is one of the largest trainers of apprentices in Canada. This is a very successful consortium where our students get paid co-op experience that also gives them their apprenticeship on-the-job learning competencies.

Another partnership that is well known in Ontario is the Hydro One consortium. Four colleges joined forces to meet Hydro One's workforce training and development needs in 2008. Since 2008, Hydro One has invested $6 million to develop curriculum, to fund scholarships and bursaries, to equip labs and to give co-op placements. Enrolment and graduation rates from the electrical engineering programs have doubled since this partnership began. This is an example of a partnership that could be a model for others in the sectors.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time for that. We'll start with the third party. Ms. Sattler.

Ms. Peggy Sattler: Thank you so much for taking the time to come here today to give your input into the bill.

Before I was elected, I was involved in a research project that looked in depth at these issues around work-integrated learning. Oftentimes, the feedback I would get from staff who worked at institutions who were trying to find placements was that it often became challenging to get enough employers on board who would be willing to host a student, as MPP Wong had pointed out. Sometimes there is additional work created such that employers may be reluctant to take on students.

I wondered if you could talk a little bit about if that has been your experience. Does it remain a challenge? Do you have ideas as to some of the strategies that might be useful to help enlist more employers to be involved in providing these placements?

Ms. Cheryl Jensen: I can give an example. The apprenticeship technician program partnership with ArcelorMittal Dofasco would be a good one. That's a huge company with lots of resources. We formed a consortium in Hamilton that includes smaller employers that don't have those resources. Through that consortium, the college and larger employers assist the smaller employers to take on co-ops and apprenticeships through this model. Through this consortium, we provide those resources that smaller employers don't have.

Ms. Peggy Sattler: You mentioned a concern about the creation of the website. Just to provide a little bit of context, in my community in London, there are a number of public colleges, that take students from the London area, as well as a number of private career colleges, and then, of course, there's Western University.

I was doing research with employers. Some of what I heard from employers was that they didn't know about the programs that were available locally or regionally, the specific programs that would have students available for them. Would it make a difference if this website was positioned more as a local or regional resource, so it's not sort of trying to get all programs on a provincial basis, but has more relevance from a local perspective to serve the needs of local employers?

Mr. Bill Summers: If I could make one comment and then ask Cheryl. That's interesting to hear your perspective. We were mainly thinking from a student perspective and hadn't thought of it from an employer perspective. So—and this is sort of an off-the-cuff reaction—I think

the idea of something that is more locally, regionally based might make more sense. But it also raises the question of whether there needs to be greater co-operation between all the educational providers in a region to focus on more of a single voice towards employers so that they have the sense of what the opportunities are.

Certainly, your earlier point about the challenge of finding sufficient placements is absolutely true. I think it continues to be a challenge for at least the colleges.

The Chair (Mr. Ernie Hardeman): Thank you very much. That does conclude the time for that. Ms. Wong.

Ms. Soo Wong: Thank you so much for coming. I just want to go back to, Ms. Jensen, your comment about the consortium at Mohawk College and working with small businesses to provide students with a learning opportunity. Has your model been replicated elsewhere in the province?

Ms. Cheryl Jensen: It has. It's used in Sudbury with Cambrian College, as well. It's worked very well in both locations. What seems to be the success is to have a champion, which in this case has been the college that's taken on the role of coordinating all of the stakeholders and bringing them together in these meetings.

Ms. Soo Wong: So you need a willing host—

Ms. Cheryl Jensen: Absolutely.

Ms. Soo Wong: —meaning the community colleges in their area where it's located. Okay. I'm glad to hear that.

The other piece I heard—I wanted to get the feel from either one of you, Mr. Summers—do you believe, in your organization, Colleges Ontario, that the government should be involved in regulating work-integrated learning in terms of providing directions etc.? Does your organization, Colleges Ontario, have a position on that?

Mr. Bill Summers: We don't have an official position. I think one needs to segregate workplace co-op opportunities that are part of the academic requirements of the institution and those that are beyond the academic requirements. Our concerns would only be with what's part of the academic requirement.

I think the advisory council idea has sort of a soft way to get into this. I don't know that we'd see a need for the province to start regulating how we do it. The advisory council would be one way to bring stakeholders together to talk about best practices, sharing experiences, without moving into a regulatory framework.

Ms. Soo Wong: The previous witness talked about every co-op/experiential learning being paid. Can I get an opinion from you, Ms. Jensen? You're working in that sector fairly hands-on. What would you think the small businesses or the broader public sector would consider this? Would that become a hindrance for those kinds of experiential learning?

Ms. Cheryl Jensen: I think it's something that we would have to really study based more on discipline rather than on whether it's a co-op or an internship. For example, our co-op programs at Mohawk are all—if they're mandatory co-op, they're expected to be paid. We have many clinical placements in our health-related fields that are not, and so that would have to be considered as a separate initiative in order to see what that would mean in terms of the players at the hospitals, the clinics, the private clinics that hire our students for those clinicals.

Ms. Soo Wong: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. The official opposition: Mr. Chudleigh.

Mr. Ted Chudleigh: Ms. Jensen, you suggested that Mohawk is one of the largest co-op colleges in Ontario. Do you find the employers that would offer positions for students?

Ms. Cheryl Jensen: Yes, we have a co-op office with consultants that work with employers, find new employers and bring those employers to the college or the students to the industry for interviews. As was said earlier, those consultants then follow up with the students when they're out on co-op, visit them, visit the employer, and then the students write a report for their co-op term at the end that is evaluated.

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Mr. Ted Chudleigh: And the number of employers you find is sufficient to cover all of the students at one co-op?

Ms. Cheryl Jensen: In general, yes. It depends on the market. It depends on the economy at the time but, in general, yes.

Mr. Ted Chudleigh: I understand. This report they write, is there part of it that is similar to an exit interview? Do they rate their experience in the—

Ms. Cheryl Jensen: Yes. The students rate their experience and the employer rates the student's experience. It's like—

Mr. Ted Chudleigh: How long have you been doing this?

Ms. Cheryl Jensen: How long have we been in co-op?

Mr. Ted Chudleigh: No, you personally. A long time?

Ms. Cheryl Jensen: Over 25 years, yes.

Mr. Ted Chudleigh: Oh, okay. You have some experience.

Ms. Cheryl Jensen: A little bit, yes.

Mr. Ted Chudleigh: Yes. Have you noticed a change in the general sense as to the student comments over that period of time regarding their satisfaction with the experience?

Ms. Cheryl Jensen: I think the students, over the time that I've been involved with them, for that length of time, have always been very satisfied with their experience. The benefit that we have of having co-op consultants is if the experience isn't working out, we can pull a student out of an experience and get them into another one.

Mr. Ted Chudleigh: Good. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes your presentation. We thank you very much for taking time to come in and speak with us this afternoon.

Mr. Bill Summers: Thanks very much.

MR. ANDREW LANGILLE

The Chair (Mr. Ernie Hardeman): Our next presenter is Andrew Langille. Thank you very much, Andrew, for coming in this afternoon. As with the other presentations, you'll have 10 minutes to make your presentation, and then we'll have questions and comments from the three caucuses. Your 10 minutes start right now, sir.

Mr. Andrew Langille: Thank you, Mr. Chair. Thank you for the opportunity to appear before the Standing Committee on Social Policy to comment on the proposed Learning Through Workplace Experience Act, 2014.

By way of introduction, I'm a lawyer who practises mainly in the areas of employment and human rights law. I hold a masters of law degree from Osgoode Hall Law School and my graduate research there focused on the legal regulation of the school-to-labour market transition. I have always been a strong proponent of work-integrated learning, and I welcome this chance to offer comments on the legislation.

I'd like to commend the member on the Learning Through Workplace Experience Act, 2014. It's a well-conceived piece of legislation, and I'm sure that it will receive support from all parties.

The critical thing that this legislation does is set up an Advisory Council on Work-Integrated Learning. This is a sorely needed development, given the growing prominence of work-integrated learning in Ontario's post-secondary education system. Simply put, currently there isn't a forum that brings together stakeholders to specifically address a multitude of issues arising from work-integrated learning.

This legislation is a step forward in getting a handle on work-integrated learning and bringing together key groups within the post-secondary education system. The Advisory Council on Work-Integrated Learning would be a welcome new voice in post-secondary education in Ontario.

I want to comment on the lack of workplace law prtections for students. Students engaged in work-integrated learning and experiential education often lack critical workplace protections. I'm going to run through a high-level overview of these exclusions.

Under the Employment Standards Act, 2000, students are targeted by two exclusions. The first, under subsection 3(5) of the ESA, completely excludes high school, college and university students from all the protections under the ESA when they're undertaking work-integrated learning as part of an academic program. The second, under subsection 2(1) of Ontario regulation 285/01, excludes professional trainees in enumerated professions, such as teaching, from ESA protections related to minimum wage, overtime pay and hours of work.

Students engaged in unpaid labour are completely excluded from the Occupational Health and Safety Act due to the need for a worker to receive monetary compensation to attract protections granted under OHSA. This exclusion under OHSA is extremely powerful and excludes a large number of young people engaged in the school-to-labour market transition from critical protections.

It should be noted that Minister Naqvi, in his previous capacity as Minister of Labour, did include reforms aimed at ending this exclusion in Bill 146, but I would submit that this legislation has not yet passed the House.

Workers' compensation protections for secondary and post-secondary students are spotty in Ontario under the Workplace Safety and Insurance Act. While students receive protection under WSIA for mandatory work-integrated learning and experiential education activities, any non-mandatory or voluntary programs do not attract protection under WSIA. This creates a situation where students are being left vulnerable to the possibility that critical injuries would go uncompensated in certain cases, or they would have to resort to litigation to recover compensation.

The deaths of Aaron Murray here in Ontario and Andy Ferguson in Alberta highlight how students undertaking unpaid internships in the context of school programs face heightened risks within the workplace.

I want to run through some overarching concerns related to work-integrated learning. Already, employers are replacing paid employees with students required to undertake unpaid labour. This is most evident in the hospitality industry, but it's certainly a growing problem that needs to be addressed immediately.

Work-integrated learning has grown in popularity over the past few decades in Ontario, but one wonders why students need to take unpaid internships or other forms of unpaid labour which involve cleaning hotel rooms, busing tables or conducting security patrols at night. It strikes me that a fair amount of the work-integrated learning requirements are excessive and unnecessary.

There's a reality that students from historically marginalized communities have a reduced ability to undertake unpaid labour and face a new glass ceiling in entering certain industries. There are also deep gender divisions within work-integrated learning. Certainly one sees this with excessive demands for unpaid labour in traditionally female-dominated academic programs like teaching, registered dietitian programs, social work and nursing.

There is also the issue that work-integrated learning is shifting training costs onto the backs of students and their families. Canadian employers already are spending half of what American employers do. This shift towards unpaid positions further exacerbates this long-term trend, and I wonder about some of the problematic issues arising from it.

All of these concerns give me pause when contemplating how work-integrated learning is currently being deployed in Ontario.

I want to end with providing a few comments on the overarching position that young people are facing in Ontario. The exploitation of students and young workers who are in an unequal position with respect to bargaining power and thus relatively defenceless against a denial of

a living wage is not only detrimental to their health and well-being, but casts a direct burden for their support upon the wider community.

The rise of unpaid internships, temp agency and low-wage service jobs all represent aspects of the increasingly rocky school-to-labour-market transition that youth endure in Ontario's post-financial-crisis economy. This economy is characterized by high youth unemployment, a disturbing level of underemployment, stagnant wages for most young workers, growth in precarious employment, heightened insecurity about employment prospects and a pervasive sense that things are getting worse.

Young people fear that they have been deemed expendable as they fall further and further behind what previous generations have achieved. This fear is justified, as so many young people struggle to secure a steady toehold in the labour market and cannot achieve any semblance of social or economic security.

Beyond the worries arising from the labour market, young people have a range of deeper pressures in their lives. The cost of housing is skyrocketing, tuition fees for post-secondary education have risen unabated for the better part of two decades and child care remains unaffordable for many young families. All of these trends point to an abject lack of intergenerational equity in Ontario. This generational spending gap is becoming more pronounced, and there is a distinct possibility that Ontario is setting itself up for further economic damage arising from the failure to make the necessary investments today in young people and their families.

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Going forward, I urge all of you and your colleagues to address the growing structural problems related to the school-to-labour-market transition. Furthermore, I urge the political parties here in Ontario to consider implementation of ameliorative policies to address Ontario's growing deficit in intergenerational equity and begin to close the intergenerational spending gap. A critical piece in addressing intergenerational equity is ensuring that young people have access to adequate protections during the school-to-labour-market transition, something that they do not have right now.

Thank you. Those are my comments for today. I'm happy to answer any questions that you may have.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We'll start the questions and comments with Ms. Wong.

Ms. Soo Wong: Thanks very much, Mr. Chair, and thank you, Mr. Langille, for coming here today.

I asked a question of previous witnesses: In terms of education for the employer—because you mentioned the safety issue—can you elaborate a little bit further? What mechanisms would you suggest to this committee in terms of educating the employer about the workplaces, to ensure safety? You commented about the potential tragedies and what have you. So how do we educate? Especially some of the smaller employers don't have the resources to deal with that piece. As a human rights lawyer but also as a lawyer dealing with employment law, could you give us some examples that we could do in terms of improvement in this area?

Mr. Andrew Langille: I think passing Bill 146 is an absolute necessity. Beyond that, the Ministry of Labour needs to have additional funding for occupational health and safety inspectors, so that they have the ability to do proactive education campaigns, visit more small employers and educate employers about the requirements under the Occupational Health and Safety Act.

I think there's a definite role for the Chief Prevention Officer in educating employers. I think some of the steps that the Ministry of Labour has taken as of late are good, but clearly, much more needs to be done.

Right now, employers are utilizing students in high-risk situations. They're sending them up on ladders, 30 feet up. They're simply not covered under the Occupational Health and Safety Act. It's bizarre. I want to address this point: Students are not covered under the Occupational Health and Safety Act, but if they fall and they're injured, they're covered, in certain cases, under WSIA. So you have a situation where somebody can get injured and not have any protections there, but then, once they're injured, get compensation for their injuries. I think that's somewhat ridiculous.

Ms. Soo Wong: Okay. The other question I have for you is this: What do you think, in your opinion, would need to be done to improve the way we deal with work-integrated learning in our post-secondary and to provide opportunities? Because at the end of the day, you want to provide opportunities for all students. Would you suggest some of the various best practices out there that we should consider?

Mr. Andrew Langille: Simply put, we don't have a lot of information about how these programs are being deployed currently at colleges, universities or in private career colleges. I think that your point earlier about private career colleges is important. There are a lot of issues in that area.

In the wake of Aaron Murray's death, I think it's incumbent upon Minister Duguid and the Ministry of Training, Colleges and Universities to conduct a full audit of every single work-integrated learning program in the province. In the wake of Andy Ferguson's death, in Alberta, the Alberta government ordered a complete review of every program in the province. I think something like that needs to happen here, very quickly. Young people are dying because of these issues.

Ms. Soo Wong: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. The official opposition: Mr. Chudleigh.

Mr. Ted Chudleigh: You were concerned about the protection of students when they are working in a co-op position. The colleges, I think, would suggest that they have some responsibility in protecting the students. You would disagree with this?

Mr. Andrew Langille: Colleges, universities and private career colleges certainly have a role in protecting young people. I would not dispute that. The question in my mind is, are they properly protecting young people right now?

I think, in the wake of Aaron Murray's death, there are some very difficult questions that have to be asked. But placing somebody in a position where they're working upwards of 20 hours a day between an unpaid internship as part of an academic program and then paid employment to fund themselves—I think that raises some very difficult questions. I think there's a role for government to provide some oversight to colleges, universities and private career colleges, something that isn't being done right now.

Mr. Ted Chudleigh: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. Sattler.

Ms. Peggy Sattler: Thank you very much. I was interested in your observation that work-integrated learning shifts training costs to students and their families. But you're not opposed to work-integrated learning. I wonder, would you see a role for government in providing employer subsidies so that the employers can hire more students in work-integrated learning programs? Would that address the concern about this shifting the burden of training costs?

Mr. Andrew Langille: It comes down to this in my mind—you have a couple of options here. The burden is being cast too heavily on the backs of students, so I think a number of things have to be considered. You could look to cutting out tuition for periods where students are engaged in unpaid labour as part of an academic program and then compensate the colleges and universities accordingly, or you could move to a system of grants to provide young people with the ability to provide for the necessities of life while they're undertaking unpaid labour as part of academic programs.

The issue, in my mind, in the case of Aaron Murray's death, is that he was working as a manager at a McDonald's during the day and then going to work as an unpaid intern at Trent University at night. That raises any number of questions around hours of work and whether somebody is getting too tired to think properly. I think exhaustion was a critical factor here.

Simply put, you need to strike a balance between the needs of the employers, the needs of students and the needs of the wider economy. I don't think the balance is necessarily being struck right now with the current situation. The status quo simply isn't working, and I think the extended amount of attention to issues related to unpaid labour and unpaid internships and precarious work related to young people is a testament to that.

Ms. Peggy Sattler: The legislation, the Learning Through Workplace Experience Act, talks about one of the mandates of the council is to identify resources and supports for post-secondary institutions to "facilitate the effective delivery of work-integrated learning programs." Do you see that aspect of the mandate—is that where some of these very critical concerns that you've raised about ensuring protection for students when they are doing these programs would be addressed?

Mr. Andrew Langille: Certainly, I think there's a role for the council, but at the same time, there needs to be greater oversight from the Ministry of Training, Colleges and Universities, the Ministry of Education and the Ministry of Labour in this area. The school-to-labour-market transition for students in Ontario is becoming very rocky. All parts of government need to do a much better job, be it in the public sector directly or broader public sector organizations such as colleges and universities.

Ms. Peggy Sattler: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. That does conclude the time that was available.

Mr. Andrew Langille: Thank you, Mr. Chair.

The Chair (Mr. Ernie Hardeman): We thank you very much for your presentation this afternoon.

EDUCATION AT WORK ONTARIO

The Chair (Mr. Ernie Hardeman): Our next presenter is Education at Work Ontario: Lisa Whalen, manager, co-op and career services, and Kirk Patterson, member, government relations committee. Good afternoon, and thank you very much for making time to be here this afternoon with us. As with the previous delegations, you will have 10 minutes to make your presentation and then we'll have questions and comments from the committee. Your 10 minutes starts now.

1730

Mr. Kirk Patterson: Thank you very much. First of all, I'd like to thank the committee for this opportunity to make comments on Bill 172, and I would like to thank the MPP from London West for proposing this legislation. My name is Kirk Patterson, and my colleague to my left is Lisa Whalen. I work at the University of Waterloo in the co-op department, and Lisa is from Georgian College, at the co-op department. Between us, we have over 50 years of co-operative education, and we want to comment on work-integrated learning in respect to co-operative education. This form of work-integrated learning, or co-op as we refer to it, is not only offered provincially and federally; it is one that's offered internationally and worldwide, and as such has certain standards that we try to meet under the federal association for co-operative education.

We are here, as you mentioned, on behalf of Education at Work Ontario, which represents the voice of co-operative education for colleges and universities across the province. In Ontario, there are over 40,000 co-op students, 800 co-op programs and over 37 post-secondary institutions, and being part of the largest post-secondary co-op province in Canada, this number continues to grow. Co-operative education in Canada began at the University of Waterloo, as many of you may know, in 1957, and in the community colleges began in Georgian in 1968; Fanshawe and Mohawk started in 1969. Co-op is "learn as you earn," and is an integral part of students' learning and career development and success.

Education at Work Ontario strives to promote and foster co-operative education of the highest quality while ensuring an integral partnership between the students,

employers, and post-secondary education institutions. The mission of EWO is to advocate and facilitate co-operative education as an essential component of post-secondary education while providing quality service and support to its stakeholders. EWO will succeed in this mission by commitment to ongoing professional development of the co-op education practitioners, who are accountable, supportive, and sensitive to the current needs and issues and education of the co-op stakeholders; promotion of ethical and professional standards for co-operative education programs in Ontario; and responsibility for the relevance and integrity of the organization's purpose, goals and objectives.

EWO was previously known as Co-op Ontario. And Co-op Ontario was formed in 1997, through an amalgamation of the University Co-operative Educators and the College Co-operative Educators of Ontario.

EWO abides by the Canadian Association for Co-operative Education definition of co-operative education. A co-operative education program is one that formally integrates students' academic studies with work experience. The usual plan is for students to alternate periods of experience in career-related fields according to the following criteria:

—each work situation is approved by the co-operative education institution as a suitable learning experience;

—the co-operative education student is engaged in productive work rather than merely observing;

—the co-operative education student receives remuneration for work performed;

—the co-operative education student's progress on the job is monitored by the institution;

—the co-operative education student's performance on the job is supervised and is evaluated by the employer; and

—the time spent in periods of work experience must be at least 30% of the time spent in the academic studies.

My colleague Lisa will continue on with our presentation.

Ms. Lisa Whalen: Thank you, Kirk. EWO supports Bill 172 and the establishment of an Advisory Council on Work-Integrated Learning in principle and spirit. It has the potential to push a solid co-op strategy along with other forms of WIL. We have many questions. We wish to stress, with the forming of this council, the importance of clear definitions and standards. These are vital.

Institutions, students and employers need to have a clear understanding of what each type of WIL is and isn't. The HEQCO study on work-integrated learning defined the terminology of types of placements and work terms. This could be used as a reference. We all know of institutions that use the term "co-op" as a marketing tool—but is it a true co-op by definition? This could lead to implications with the CETC, which is the Co-operative Education Tax Credit, which clearly states that a qualifying co-operative education program generally parallels "those established by the Canadian Association for Co-operative Education for defining a co-operative education program."

Our association worked diligently and hard in lobbying and meeting with our government to initiate the CETC. EWO would not want to see this advantage for employers with the CETC undermined.

Also in the MYAA report, the annual multi-year accountability agreement, it indicates under work-integrated learning the government's interest in expanding WIL, but the only definition given is for co-op.

Internship—well, we could talk about that one for hours—paid or unpaid? How is it determined? Definitions are convoluted and vary from institution to institution. Employers are confused.

Programs with a WIL component: Guidelines need to be put in place to help determine the best type of WIL to be offered in a particular post-secondary program, i.e., co-op is paid. Not all employers, especially NFPs, can offer remuneration. What WIL component is the best fit for a particular program and its employer recruitment? What incentives—and it doesn't always need to be financial—would encourage more employers to become involved? We asked most students what their definition of "success" is. Their response was, "A job." Where does entrepreneurship and applied research fit in? Many institutions are offering entrepreneurship co-ops. Is TalentEdge viable for these types of co-ops? What about start-up funds for new programs with a WIL component? What type of career advising and employment preparation would be provided to students in these WIL programs?

Another one of our issues and questions is the membership of the council. The need to bring together an advisory council with appropriate stakeholders from WIL employers, associations, PSE institutions, HEQCO, students involved with WIL, graduates, economic development and labour market sectors is crucial in order to make informed recommendations to the ministry. A concern is members on the council who may not know or understand the managing and sustaining of work terms and placements with universities and colleges. EWO co-op institutions work closely in partnership with employers and associations and have the ability to provide necessary co-op stats and data.

Under mandate item 3.1(6)(d) in the bill, there has been concern expressed regarding the statement, "Further, it is in the interest of the people of Ontario that no student enrolled in a post-secondary program that includes a work-integrated learning component is denied the opportunity to take part." In many co-op programs throughout the province, there are enrolment guidelines and academic standards to participate in co-op.

We believe that the implementation of this advisory council falls into place with Ontario's Differentiation Policy Framework for Postsecondary Education, including section 3.3.1, "Jobs, Innovation, and Economic Development." It is a known fact that students who have experience in their field of study through co-op work terms will more likely obtain a graduate position because of their experience, which in turn leads to an increased grad employment rate, employer satisfaction, student

satisfaction and an increased number of graduates employed full-time in a related program.

Section 3.3.3, "Student Population": Student demographics are changing. Colleges and universities are seeing an increase in the international student population. These students want Canadian work experience, so many enrol in co-op programs. How do we encourage employers to hire?

A student is not always young. We have many mature students returning to school, with the main goal being to obtain employment. How can we assist and again encourage employers to hire? What incentives could be provided?

Council could investigate and recommend changes on co-op students not covered under the Employment Standards Act. Most employees and employers in Ontario are covered by the ESA. However, the ESA, as the gentleman before us said, does not apply to certain individuals and persons or organizations for whom they may perform work, including individuals performing work under a program approved by a college of applied arts and technology or a university.

EWO strongly urges the council on work-integrated learning to identify effective strategies, advise and recommend to the ministry on what are WIL-experiential learning opportunities really intended to provide to a participating student; how much WIL do our programs already offer to students, and are those WIL opportunities that already exist actually fulfilling their promise and intent? We definitely need clarity on WIL definitions and standards; marketing and promotion on the benefits of WIL; resources, start-up funds and incentives; and utilizing existing organizations such as Education at Work to ensure there is no duplication of resources. EWO has its own Web portal that reaches out to institutions and employers.

Again, we thank you for listening to our questions on Bill 172. The importance of being transparent and including the right stakeholders is imperative for the success of this council. Co-op does make education work. With collaboration on definitions and standards, WIL programs will give students quality work experiences, the tools, knowledge and skills they need to become contributing members of society.

1740

We'd also like to thank Peggy for bringing this bill forward. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time. We start with the official opposition.

Mr. Ted Chudleigh: We've heard today that there are a number of concerns regarding co-op programs and they seem to focus around oversight, as to who exhibits the oversight to make sure that the students are safe, they're getting an experience that is beneficial to them, along those lines. If oversight was the issue, where do you see that oversight taking place? Is that the responsibility of the colleges or universities? What responsibilities do the students have towards that oversight? And what responsibility does the government have towards that oversight?

Ms. Lisa Whalen: The colleges' and universities' co-op is paid, so we make sure that that employer does have WSIB. We have approached the Ministry of Labour to look at co-op students being involved in the Employment Standards Act.

Mr. Kirk Patterson: As far as individual work terms, I think most, if not all institutions—I know at our institution, we vet each employer. We make sure that the employer is offering a viable learning experience. Even this morning, I was in discussion with a prospective client who wants to hire co-op students, so I have a number of questions I go through with them: pay; coverage; what's the work experience; supervision; how are they going to be trained; what type of work term are you offering them; and what are the duties. Then we go through the list. I think each institution knows that we want to get the best for our students.

I don't like using the term, but we're not there offering slave labour to employers. We are there offering students who are bringing current knowledge to apply to the workplace so these employers can advance themselves, advance their business. It's a two-way street. They're getting the youth and talent of today and tomorrow's generation of leaders. We also want to make sure they're giving our students the best that they can offer.

As I said, we've been around for over 50 years. We've worked on developing co-op programs from the bottom right through to monitoring. In my current field as business development for co-op students, I have a very large territory, and I only want to bring in the best for the best students that we can offer.

Mr. Ted Chudleigh: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Sattler.

Ms. Peggy Sattler: Thank you. It's wonderful to see you both again.

I wanted to talk a little bit about the lack of clarity on definitions around WIL. Co-op is actually one of the forms of work-integrated learning that is probably the most spelled out, as to what it's supposed to involve. As you know, Lisa, from the research project that we participated in, there was a wide variety of student reports about their experiences in co-ops. Some said they weren't paid; some said they weren't evaluated, they weren't supervised. Their placement did not meet many of those conditions or characteristics of what a co-op work term is supposed to involve.

I wonder, within the sector, have you had a discussion about how this can be? Why are students reporting that they're doing these co-op work terms and yet they're not falling within the definition of co-op?

Ms. Lisa Whalen: I could go on for a while about that one, but students, even if they're in a field placement or a practicum or a clinical or an internship, they still call it "co-op." I can give a prime example of when we did the KPIs, and what came back was a program, general arts and science—it got rated high on the KPIs for its co-op program. It's not a co-op program. So employers don't understand the differences; students don't understand the differences.

Co-op is the only work-integrated learning that has a definition that has remuneration in the definition. Field placement is not paid. Internship is paid sometimes, and sometimes not. Clinical is not paid. Practicums are not paid. In-industry placements are not paid. Co-op is the only one that has that.

We're the only one with a really clear definition, and that's because of the lobbying and a lot of work our provincial association has done, our national association has done and our worldwide association has done.

So, being a little biased when it comes to co-operative education, a lot of other forms of work-integrated learning can look at what we do and maybe learn from it. Our students are expected to complete learning outcomes when they're out in their co-op. They are expected to submit a work-term paper, with a reflection paper on what they've learned while they were out there. It is part of their credit.

Ms. Peggy Sattler: Okay. I just want to slip in another question before my time runs out.

The Chair (Mr. Ernie Hardeman): Make it quick.

Ms. Peggy Sattler: You mentioned a concern about "no student enrolled in a post-secondary program ... is denied the opportunity to" participate. If that was amended to say "no qualified student," would that address the concern you raised around the academic standard?

Mr. Kirk Patterson: Yes, I think so.

Ms. Lisa Whalen: Yes. That came from quite a few universities and colleges.

Ms. Peggy Sattler: But we could address it by just adding "qualified." Okay.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes your time.

Ms. Wong?

Ms. Soo Wong: Thank you very much for your presentation.

I just want to hear from your organization: Does your organization have an opinion about colleges and universities in terms of their role in improving the work-integrated learning, in terms of opportunity for students? Does your organization have an opinion for colleges and universities on this particular file?

Ms. Lisa Whalen: I'm not sure if I understand your question. Sorry.

Ms. Soo Wong: Does your organization have an opinion for colleges and universities—because much of this co-op or work-integrated learning comes from the post-secondary. Does your organization have an opinion in terms of how the colleges and universities can improve this type of work-integrated learning in their sector?

Ms. Lisa Whalen: Yes. I think there are three issues that we mentioned in our presentation, one being the definitions and standards, and another being marketing, which includes a one-stop, right-stop Web portal. Another one includes—sorry.

Can you help me with that one?

Interjection.

Ms. Lisa Whalen: Definitely, I think we emphasized a makeup of the committee, of the advisory council, if it goes forward.

Ms. Soo Wong: Okay. In terms of the private sector—because at the end of the day, many of the employers out there are not large businesses—how do we educate and work with the small businesses, and then work with them in terms of accommodating the learning needs of the student learner but also meeting the needs of the work-places? Is there anything that you could suggest to this committee?

Mr. Kirk Patterson: When small businesses want to hire, the biggest gateway they have to get through is the wages. You have many start-ups and not-for-profits that would love to participate in co-operative education, but if they're not-for-profit, they're not-for-profit. I deal with a number of not-for-profits, and one thing they would like to see out of the government is some type of wage subsidy program or some incentive that allows them to do more hiring.

For start-ups, it's the same thing. That's why they're a start-up: They don't have the money, but they wish to hire. I think if there's a pool of funds developed that allowed the institutions to manage it for start-ups in their area, that would go a long way to improving numbers of employment.

As far as the quality of the employment, if the institutions are following the guidelines that are out there and have the art of searching out qualified and quality placements, then it will fall into place.

Ms. Soo Wong: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation this afternoon. That concludes the presentations.

As I mentioned at the start of the meeting, we do need to have a very short meeting in camera before the bells quit ringing for the vote. So if we could just adjourn this part of the meeting, then we will go into in camera to do the other issue.

The committee continued in closed session at 1749.

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